# *EAST REGION EMERGENCY MEDICAL SERVICES & TRAUMA CARE SYSTEM FY 2006-07 PLAN*

Submitted to Department of Health January 31, 2005
*Revised per DOH Recommendations April 22, 2005*
*Revised and resubmitted per Steering Committee recommendations July 15, 2005*

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Adams
Asotin
Ferry
Garfield
Lincoln
Pend Oreille
Spokane
Stevens
Whitman


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## Washington State DOH Approved Plan Modifications

To The EAST Region EMS And Trauma Care Plan

| Modification | Page Number (s) | Approved | Posted |
|---|---|---|---|
| Section IV. Prehospital, A. Communications | 15 through 20 | 1/14/2006 | 1/24/2006 |
| * Section VI. Trauma System Evaluation | 47 through 51 | 2/6/2006 | 2/10/2006 |
| Corrected vehicle information to C-1 to B-1 | 35 | 9/15/2006 | 9/18/2006 |

* Changed document page numbers

Acknowledgements

The East Region EMS & Trauma Care Council would like to acknowledge its many hundreds of EMS/TC providers, both prehospital and hospital, as well as the dispatchers/call takers, Injury Prevention and Public Education presenters, the Inland Empire Training Council, rehab providers, Medical Program Directors, each county EMS/TC council, and all of our partners in the EMS and Trauma System.

The East Region staff would like to take this opportunity to again thank ALL of the volunteers who are dedicated to making sure that the “right patient” gets to the “right facility” in the “right amount of time”. The Regional Council, the Chairs & Executive Committee, and all of the other East Region committees have provided the technical assistance necessary to administer an effective EMS and trauma system in a region that covers over 15,536 square miles (not including Columbia County).

*Thank You!*

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# I. Executive Summary:

**Authority:** The Regional Council is authorized by RCW 70.168 and WAC 246-976 to provide coordination of the East Region EMS and Trauma Care System for the nine most eastern counties of the state (Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman). The current Regional Council membership consists mainly of adults over the age of 40. This problem is not specific to the Regional Council. Many of the County EMS/TC Councils are also experiencing a lack of participation in both service and administration by the younger generation. *Goal: Regional Council and county EMS/TC councils will have membership that will carry through the retirement years of the current administration.*

**Injury Prevention & Public Education:** There is an active injury prevention initiative in the East Region. There is a need within the region to support the many injury prevention programs and resources. The Regional Council has a limited budget with which to address injury prevention and cannot meet the Regionwide needs. Therefore there is a need for other like-minded organizations to continue to provide support through injury prevention efforts and for all those involved to collaborate to maximize the impact on reducing injury. *Goal: Prevention Education Is Available Regionwide.*

**Prehospital**

**Communications:** Emergency Medical Dispatcher training is valued in the East Region. There are still 21% of dispatchers/call takers in this region that are not EMD trained to the regional standard. *Goal: By Regional Consensus All Dispatchers Will Be Nationally Certified In Emergency Medical Dispatch.*

**Prehospital Medical Direction of Prehospital Providers:** MPD input is important to system level planning and development as well as to the local county level. There are no MPDs on the Regional Council membership roster. *Goal 1: Regional Council Membership Consists of at Least One MPD.*

**Prehospital EMS & Trauma Services**: EMS Education and training is important to ensuring an adequate number of providers in the East Region system. Most local councils do not have funding to provide EMT or FR initial training in their counties, making the volunteer responsible for his/her own training expenses. There is a lack of qualified EMS/EMT instructors throughout the region. Training and education aids and equipment have been identified by providers in the regions as being needed to support their education efforts. *Goal: Prehospital EMS/TC training is provided regionwide.*

**Prehospital Verified Aid and Ambulance Services:** There are 68 licensed and verfied services in the East Region. These agencies have an ongoing 68 **l**icensed and verified services need for equipment to enhance their service. There is a need to change the min/max numbers of verified ambulance services in Spokane, Stevens and Whitman Counties. Asotin and Pend Oreille Counties have also identified a need to change recommended min/max numbers, however the council is not prepared to provide recommendation for these two counties at this time. *Goal: County Specific Needs and Distribution of Services Documents shall remain current.*

**Prehospital PCPs & COPS**: PCPs are region wide in the East Region. All nine Council Councils have developed a COP for Regional PCP #3 Triage and Transport. Changes to PCPs are made to reflect changes in the system and should be DOH approved and implemented in a timely manner. Changes to Regional PCPs are made to reflect changes in the system and should be implemented in a timely manner. This process needs to be reviewed at the DOH level. County COPs are not being maintained and improved as often as necessary nor do they require approval of the DOH. *Goal: Regional PCPs and COPs Within The Region Are Up To Date.*

**Designated Trauma Care Services**: A network of 19 designated trauma services is in place in the East Region. A primary system need for trauma services in the East Region is resource stability. There are a number of emerging system issues that either currently or potentially may impact the resource stability and trauma care. *Goal: Designated Trauma Service resources are maintained at the level necessary to meet trauma patient care needs.*

**EMS & Trauma System Evaluation – Information Management**: Not all agencies responded to the survey on the type of data collection currently being used. *Goal 1: Regional Council is Knowledgeable About Data Collection Regionwide.*

**Quality Assurance**: There is a need to expand our vision which will create more vital connections. There is also a need for more creative programming. Perhaps this could be accomplished by developing a questionnaire concerning topics that would stimulate the interest of MPDs, ER physicians, advisors from the Spokane Fire Department, American Medical Response and of course the trauma surgeons. Also needed is additional membership on the QIC. Active recruitment to fill positions on the committee is a priority. *Goal: Regional Participation in QI is Consistent.*

**All Hazards Preparedness – Prehospital:** 1) The FCC has announced that HEAR Radio will be moving to narrow band by 2007, so a new communications system may be necessary. Funding to support this project is not available through Regional Council funds. 2) At a minimum, Awareness 160 is necessary for prehospital providers. 3) Information on WMD equipment needs are not available. 4) The Regional Council has no knowledge of specific All Hazards Mutual Response Agreements in place. 5) Information on interoperability between disciplines is not available. 6) There is a need to develop a PCP to cover Trauma and Burn Care for 50 burn patients per million population per day. *Goal: Identify Prehospital WMD needs.*

**All Hazards Preparedness – Hospital:** 1) The hospital plan is required to be updated. 2) All disciplines involved in all hazards events still need training. 3) It is imperative that all disciplines be committed to participate in the planning and implementation of the drill and/or exercise at the very beginning of the planning process. 4) Survey that will identify hospital capability and needs to meet the goal of providing trauma and burn care to at least 50 severely injured adult and pediatric patients per million of population. *Goal: Hospital All Hazards Preparedness Meets Requirements Of The HRSA Benchmarks.*

**Changes to Plan Requiring DOH Approval**: None at this time.

# II. Authority – Regional System Coordination

## A. Regional Council Coordination

**System Status Regional Council's Coordination Role**: The Regional Council is authorized by RCW 70.168 and WAC 246-976 to provide coordination of the East Region EMS and Trauma Care System for the nine most eastern counties of the state (Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman).

**Council Operations**: There are seven working committees consisting of volunteers that provide leadership for the Regional Council. They are: Communications, Injury Prevention and Public Education, Hospital Planning, Rehab, Training & Education, Prehospital & Transportation, and Information Technology. There are also four administrative committees consisting of volunteers that provide leadership for the Regional Council. They are: Finance, Bylaws, Membership, and Chairs & Executive.

Regional Council staff includes:

1) A full-time administrative assistant who works directly with the Chairs an Executive Committee to ensure that contract deliverables and those projects that directly effect the development and planning of the East Region EMS and Trauma Care System are accomplished;
2) One part-time employee who works with the administrative assistant on both EMS and Disaster Preparedness projects; and
3) One AmeriCorps Vista volunteer who works in the office on a full-time basis. This position works with committees on EMS and disaster planning projects which directly enhance the EMS & Trauma System.

Collaboration with community partners on projects such as communications, injury prevention, and disaster preparedness, has enhanced the East Region EMS and Trauma Care System.

**Mission Statement:** Our mission is to establish and promote a system of emergency medical and trauma services, which provides for timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury.

## 2. Need Statement

**Regional System Coordination Needs**: The Regional Council is an all-volunteer organization dedicated to the success of the regional EMS and Trauma Care System. A lack of interest by the younger generation in the administration and/or participation of/in the EMS & Trauma Care System has been noted by the Regional Council. The current membership consists mainly of adults over the age of 40. This problem is not specific to the Regional Council. Many of the County EMS/TC Councils are also experiencing a lack of participation in both service and administration by the younger generation.

## 3. Goals/Objectives/Strategies

**Goal 1: Regional Council and county EMS/TC councils will have membership that will carry through the retirement years of the current administrations.**

**Objective 1**: ***County EMS/TC Councils will be asked to encourage participation in county and regional council administration on an annual basis.***

**Strategy 1:** Language developed in the annual contract between the EREMSTCC and the individual county EMS/TC councils will address membership.

**Goal 2: System cost can be estimated**

**Objective 1:** ***Identify methods that will provide information on system costs by November 2006 and incorporate estimated system cost in the 2007-2009 biennial plan.***

**Barrier: Participation by all required agencies and stakeholders.**

**Projected System Costs - Biennium**

| | |
|---|---|
| **Estimated System costs:** | **$185,000** |
| **Regional Council Cost**: | **$160,000** |

**Barriers:** Regional Council membership depends on the county EMS/TC council membership in each of the nine counties. If the county councils cannot expand their membership and/or provider pool, it is most likely that the Regional Council membership will also not increase.

# III. Injury Prevention & Public Information / Education

## A. IPPE

### 1. System Status

***Table A. Regional Injury Data featuring Top Four Causes***
**Injury Rate per 100,000**

| *Non-fatal Injuries* | *1998-2002* | State | *Fatal Injuries* | *1998-2002* | State |
|---|---|---|---|---|---|
| Falls | 355.7 | 281.0 | Suicide | 13.8 | 12.8 |
| MVA (to occupants, pedal-cyclists, motorcyclists and pedestrians) | 75.4 | 63.3 | MVA (to occupants, pedal-cyclists, motorcyclists and pedestrians) | 12.7 | 11.6 |
| Suicide | 56.2 | 48.5 | Falls | 12.2 | 7.0 |
| Poisonings | 25.7 | 25.4 | Poisonings | 6.0 | 6.9 |

Table A. above provides information compiled from the Washington State Department of Health, Center from Health Statistics. The table identifies the leading causes of non-fatal hospitalizations and fatal injuries for Eastern Washington region 1998 through 2002. The data identifies the top four cause rate per 100,000 resident population.

Falls are the leading cause of non-fatal hospitalizations. The majority of fall related injuries happens to individuals ages 55+ years. The second leading cause is motor vehicle crashes, injury to occupants is significant in the rates and young drivers, ages 18-19 years are over represented.

Injury Prevention is an integral part of the EMS & Trauma System. The Council supports the efforts of the Injury Prevention & Public Education Committee and by contracting with Spokane Regional Health District's Injury Prevention Programs to execute the Council's injury prevention program.

***Background***

There are many organizations within the region that provide prevention education and the programs are many and varied. Prevention resources in Eastern Washington include, but are not limited to hospitals, prehospital agencies, public health, Spokane SAFE KIDS Coalition, Prevention Concepts, Spokane County Traffic Safety Commission, law enforcement and fire safety.

The EREMS & Trauma System supports the efforts of the Council's IPPE Committee which is comprised of representatives from Spokane County 9-1-1, private business, public health, fire districts to support injury prevention efforts of the committee. The IPPE Committee's primary focus is to serve as a network for injury prevention efforts throughout the region. The committee's annual significant activity since FY 2004 is to support impaired driving prevention efforts through the distribution of phone cards to young drivers. The committee also serves as a clearing house for injury prevention programs. The IPPE link on the Council's webpage offers information on injury prevention programs.

After reviewing the regional injury data, the Q&I Committee has recommended that the Regional Council focus its prevention education on falls prevention. The decision to focus education on falls prevention was not only based on the data, but also on the fact that falls are the most expensive injury to treat, and patient recovery is quite lengthy. The Regional Council's approach to Injury Prevention is to contract with an outside agency to carry out projects that are supported by regional injury data. The Spokane Regional Health District's Injury Prevention Programs is the current contractor. Funding supports a half time Regional Injury Prevention and Public Education Coordinator.

**Falls Prevention – *Seniors Up and Go Program***

Since FY 04 the Regional Council has contracted with Spokane Regional Health District to develop and implement a falls prevention program to be presented to the elderly in the eight rural counties of the region. The "*Seniors Up and Go"* program was developed and implemented with significant interest from the outlying eight counties of the region. Requests for presentations and presentations conducted surpassed the estimated number of sessions that would be facilitated in FY 04.

In FY 05 the Regional Council expanded the scope of falls prevention to include Spokane County. There is discussion about the possibility of adding an educational module to the program that would educate the elderly on signs and symptoms of depression, which may be directly related to suicides in the elderly.

***Safe & Sober Roadways (Mock Crashes) Program***

The Regional Council, through grants from the Washington Traffic Safety Commission, contracts with Prevention Concepts to provide mock drunk driving crash demonstrations at high schools throughout the region. Funds were not available in FY 04 to support this program; however for FY 05 12 mock crash demonstrations are planned to be enacted in various counties of the region.

***DUI Programs***

When available, the IPPE Committee applies for a DUI grant through the DOH, EMS & Trauma Systems office (awardees from Washington Traffic Safety Commission). The committee purchases educational material, such as phone cards, pens, pencils and other materials that can be distributed though mock crashes and other DUI programs as well as being available in the Resource library.

***Resource Library***

The Spokane Regional Health District maintains the regional Resource Library established in 1993. The library offers educational material on a number of different programs. There is an ongoing need for the availability of literature, videos and equipment to support individuals Regionwide who are involved in injury prevention efforts. Keeping a readily available updated list of resources from the Regional resource library on the East Region website is needed and currently being addressed.

**General Injury Prevention Resources**

***DUI Programs***

The Greater Spokane Substance Abuse Council (GSSAC) is administering the Minors In Prevention program that was initially developed by the East Region IPPE Committee. Since the program was turned over to GSSAC in 2002 the Council does not play a role in the implementation or review of the program's effectiveness. The program is still operating and continues to serve the Spokane Community. Additionally, GSSAC partners with the Spokane County Traffic Safety Commission to host a DUI Panel that is also active in Spokane County. There are a number of DUI Task Forces located in various counties throughout the region.

***Suicide Prevention***

Led by the Spokane Regional Health District's Injury Prevention Program, the Suicide Prevention Coalition is comprised of public and mental health professionals, survivors of suicide, and concerned citizens. The coalition strives to reach out to the community by creating awareness that suicide is preventable. Education efforts are focused primarily in the areas of senior citizens and their caretakers, medical professionals, media, and families. The coalition meets bi- monthly and is always open to new members. The activities of the Suicide Prevention Program are promoted through the EREMS Council email system.

***Helmet Safety Education***

The IPPE Committee is not at the present actively involved in the distribution of bike helmets. Educational materials are distributed through the Resource Library, housed at the Spokane Regional Health district to public schools and agencies. The Health District provides technical and educational resources to different entities in support of their helmet safety programs. Organizations involved in the distribution of bike helmets are encouraged to apply for funding through the Washington Trauma Society. The Trauma Society's distribution program is supported by the Washington Traffic Safety Commission.

***Poison Prevention***

Currently there are not any operating programs for Poison Prevention in Eastern Washington.

**2. Need Statement**

East Region injury data highlights the four top injury problems in the region, suicide, MVA injuries, falls, and poisonings. There is a need within the regions to support injury prevention programs and resources that address these injuries. The Regional Council has a limited budget with which to address injury prevention and cannot meet the Regionwide needs. Therefore there is a need for other like-minded organizations to continue to provide support through injury prevention efforts and for all those involved to collaborate to maximize the impact on reducing injury.

Based on available East Region injury data, the Regional Council has identified the need to support two injury programs and two addition regional resources. Based on the Q&I recommendations the Council supports the contract with SRHD to execute the Falls Prevention Program and the activities of the IPPE Committee. Funding to support prevention efforts comes from the council's operating budget and seeks funding from other grant sources,

specifically the Washington Traffic Safety Commission. Though the need for injury prevention is great, the funding provides only limited support. Funding support for suicide prevention is not a current Regional Council focus. As stated above SRHD suicide prevention activities are promoted through the council to the outlying counties.

Lack of funding and other resources to support injury prevention activities is an ongoing problem. The outlying counties are primarily dependent upon volunteer time and capacity. The Regional Councils injury prevention effort is reliant upon a part-time injury prevention coordinator to deliver program expertise and resources to the nine-county area.

***Need for Seniors Up and Go (Falls Prevention) – program support***

Falls are a significant injury problem in the East Region. They are the biggest cause of non-fatal hospitalization in the East Region, surpassing motor vehicle crashes and suicides. From 1998 through 2002 there have been 347 fatalities and 10,104 non-fatal hospitalizations due to fall related injuries in the Washington Eastern Region area. For the older person a fall can not only cause pain and injury but also ruin quality of life and cause loss of independence with over 40% of admissions into nursing homes triggered by a fall. Individuals over the age of 65 fall while performing everyday activities in the home, yet 30% to 40% of these falls *could* be prevented but are not.

***Need for Safe & Sober Roadways (Mock Crashes) – program support***

During the years 1998 – 2002, 364 deaths were directly caused by motor vehicle collisions in the East Region's nine counties. Motor vehicle crashes are the #2 cause of fatalities in the East Region and rank second as the cause of non-fatal injuries, with 2,144 non-fatal injuries reported during that same time period. According to the Washington Traffic Safety Commission's 1993-2001 Fatality Analysis Reporting System (FARS) 298 individuals lost their lives on eastern Washington roadways due to traffic collision where the drivers had been drinking. Drinking Driver crashes account for 30.3% of all motor vehicle related fatalities in Washington State from 1993-2000. Drivers ages 21-50 comprise the majority of the drinking drivers at the wheel of those fatalities. Over an eight-year period, drinking drivers were involved in 27% of all traffic deaths statewide. A majority of the fatal crashes happened on county roads (46), state or US highways (33) and city streets (26). In crashes that involved a drinking driver, seatbelts were not used in 71.2% of the incidents.

Mock Crashes illustrate how potential alcohol- related scenarios could happen to any high school student, and they dramatize the social and healthcare problems associated with underage drinking and impaired driving. Lack of funding and other resources may result in the program not being available after September 2005. Program implementation is reliant upon volunteer capacity. Need for Regional Resource Library - resource support.

There is an ongoing need for the availability of literature, videos and equipment to support individuals Regionwide who are involved in injury prevention efforts. Keeping a readily available updated list of available resources from in the Regional resource library on the East Region website is needed.

***Need for Child Death Review Project – resource support***

The Regional Council identified the need for participation in the statewide child death review process and has assigned the Injury Prevention Coordinator to participate in the University of Washington/Harborview Injury Prevention and Research Center Child Death Review Project. Continued participation is needed to keep the region informed about issues related to child deaths.

**3. Goals**

**Goal 1: Prevention Education Is Available Regionwide**

**Objective 1**: ***Reduce the high rate of fall injuries and deaths among East Region's older population annually through focused falls prevention education***.

**Strategy 1**: Implement an evidence-based senior falls prevention program by June of 2006 and provide reports periodically during the biennium for targeted groups.

**Strategy 2:** The IPPE Coordinator, contracted with EREMS through SRHD, under the guidance of the IPPE Committee will continue throughout the biennium to carry out the following and will report monthly on progress:

- Build Falls Prevention program infrastructure and resource base
- Recruit and train community Falls Prevention liaisons continually throughout the year.
- Execute and deliver the Falls Prevention program in the nine EREMS counties.
- Heighten community awareness through increased distribution of 1,000 brochures and informational materials.
- Build the level of collaboration for falls prevention by increasing EREMS IPPE membership to represent all nine counties of the region by 6/2007.
- Evaluate the effectiveness of a best practices model for senior falls prevention when implemented in a community setting and report findings.

**Objective 2: Reduce fatalities and injuries caused by traffic crashes through working annually with the emphasis areas of the Washington Traffic Safety Commission's Target Zero Initiative and educating the public on risks.**

**Strategy 1**: Contract for a minimum of twelve (12) mock drunk driving car crashes within the nine counties between October 2004 and September 2005 and between October 2005 and September 2006 and evaluate and report attitudes and behaviors.

**Strategy 2:** Administer pre and post tests to youth attending the presentation. The pre-test will measure their attitudes and behaviors concerning impaired/dangerous driving. The post-test will measure the effectiveness of the program and changes in perceptions regarding impaired/dangerous driving.

**Objective 3:** ***List and update the available IPPE education resources from the library on the IPPE page of the Regional Council's website quarterly throughout the biennium.***

**Objective 4:** ***Develop data driven youth focused injury prevention education strategies for the East Region and recommended them to the Multi-Disciplinary Child Death Review Team by June 2006.***

**Strategy 1:** The IPPE Coordinator will represent the Council on the Spokane County Multi-Disciplinary Child Death Review Team to examine unexpected child deaths and recommend injury prevention education strategies by June 2006 to prevent similar deaths in the future.

**Projected Cost**

| | |
|---|---|
| **Estimated System Costs** –**Biennial** Regional IPPE Projects | **$438,000** |
| **Regional Council Cost** – Supports IPPE Coordinator | $78,000 |

**Other Regional Costs**

- Mock Crashes – *Outside funding* $40,000
- Resource Library – *Outside funding* $10,000
- Spokane Regional Health District IPPE support (does not include outside grant funding) $310,000
- Other Resources – to numerous to calculate

**Barriers**

Continued funding is always a challenge for the Regional Council. Some programs are dependent upon outside funding.

Mock crashes can be challenging to plan. Coordinating necessary resources such as a crashed car, local law enforcement, paramedics, parents, the media, even a funeral director is very labor intensive. EREMS must compete at state-wide level to the Washington Traffic Safety Commission for funding for future years.

Professional development of the individuals executing the prevention activities in the individual counties is reliant upon volunteer capacity.

Programs are reliant upon a part-time injury prevention coordinator to deliver program expertise and resources to the nine-county area, while maintaining administrative responsibilities.

# IV. Prehospital

## A. Communication (Washington State DOH Approved Plan Modifications - 1/14/2006)

### 1. System Status

*Table B. Dispatchers with EMD Training by County*

| County Name | Total # of Dispatchers in the County | EMD Training Program/s used in the County (if none indicate so) | # Dispatchers within the county who have completed EMD training from a course in column #3 |
|---|---|---|---|
| Adams | 12.6 | Medical Priority | 1 |
| Asotin | *0 | None | 0 |
| Ferry | 10 | Medical Priority | 10 |
| Garfield | 8 | Medical Priority | 8 |
| Lincoln | 9 | Medical Priority | 7 |
| Pend Oreille | 7 | Medical Priority | 7 |
| Spokane | 42 | Medical Priority | 34 |
| Stevens | 12 | Medical Priority | 10 |
| Whitman | 20 | Medical Priority | 18 |
| Totals | 121.5 | | 95 |

Prehospital communications in the East Region is a complex system element that is critical to the success of the EMS and trauma care system. Access to 911 and dispatch of emergency services is the first link in the communications system. The East Region has adopted the Medical Priority EMD protocols as the regional standard. Dispatchers and/or call takers who pass the course are then nationally certified through the National Academy of EMD. The DOH, EMS and Trauma office does not have authority (identified in RCW and WAC) over EMD certification. Certification through the National Academy of EMD identifies standard of care for dispatchers and call takers. The Department of Justice provides oversight to Washington State 911 centers.

The East region 911 Centers generally operate under the supervision of the County Sheriff's Office that includes Fire/ EMS and Law Enforcement dispatch. Spokane County 911, Law Enforcement and Fire/EMS dispatch are all separate entities.

Table B. above identifies the number of dispatchers by county (those that are involved in EMS dispatch), the type of EMD training program they participate in and the number of **EMD** trained dispatchers in the county.

In Spokane County the 911 center transfers all EMS calls to Fire dispatch. The 911 operators and Law Enforcement Dispatchers are not EMD trained or included in the number of dispatchers for Spokane County.

In Adams County 911 calls go directly to the Ritzville Sheriff's Department with appropriate calls then routed to the Othello Sheriff's Department. At this time there is no EMD trained dispatchers and/or call takers in Ritzville. Othello has only one EMD trained dispatcher in their center.

There are no dispatchers in Asotin County because of the 911 consolidation with WHITCOM in Whitman County.

**Current Existing Regional Communication Resources:**

***Effective E-911 Access***

By meeting state standards all 9-1-1 centers have enhanced capabilities and are Phase I and Phase II compliant. Recent surveys indicate that East Region E-9-1-1 centers meet all national standards and are Phase I and Phase II compliant. Dispatch Centers are VoIP (Voice over Internet Protocol) capable.

Enhanced 9-1-1

Dispatch centers utilize enhanced systems that displays callers address and phone information as well as jurisdiction information.

Phase I: Wireless telephone companies are required to provide 911 cell caller phone numbers and the cell tower location to all dispatch centers.

Phase II: Wireless telephone companies are required to provide the dispatch center with the cell caller's location using GPS, technology providing the cell tower and phone have that capability. If the caller is moving, some dispatch centers are capable of tracking the location with mapping. Older cell phones do not have this technology.

VoIP: Voice Over Internet Protocol allows a caller to contact a local 911 center via the Internet, with the purchase of a separate package. These calls are not direct dial to the local 911 center. They are routed through the VoIP provider's computer network and re-routed to the 911 center that has been identified by the customer.

***Dispatch Of EMS By Trained Emergency Medical Dispatchers***

The Regional Council has identified the preferred regional standard of training as the Clawson Emergency Medical Dispatch (EMD) program. Dispatchers and/or call takers who successfully complete the Clawson Emergency Medical Dispatch course receive national certification from the National Academy of EMD. Currently in the East Region 79% of dispatchers and/or call takers are EMD trained.

***Provisions For Bystander Care With Dispatch Assistance***

Dispatch assistance for bystander care is a formalized training program incorporated into the EMD protocols, reinforcing the need to have all dispatchers EMD trained. Spokane, Stevens and Whitman Counties are the only counties that are staffed with enough dispatchers to provide this service consistently. The other 6 counties are very rural and may not have the staffing capability to provide bystander care with dispatch assistance.

***Ability Within The Region To Track Average Time To Contact A Live Person At 911 Centers***

Technological advances have enhanced the ability to track the time it takes for the 911 caller to contact a live person at 911 Centers. Calls are recorded through computer programs such as DATA GATOR, Phone system RMS, Magic Reporting system, and various other tracking systems in the East Region. These systems also provide statistical information regarding average times and number of calls. This data is available in dispatch centers throughout the region and is disbursed to EMS agencies in various ways.

***Time Tracking Methods From Initial 911 Call To The Dispatch Of The Responding EMS Agency***

The CAD system is predominantly used within the East region. There are various methods used within the region to track the time from the initial 911 call to the dispatch of responding EMS agencies. There are a few dispatch centers that have calls transferred to them from the larger dispatch centers. Methods used to track the time include logging time, databases, phone and paging systems.

***Overload Of Dispatch Centers***

In this region, most overloads of dispatch centers occur when there is a multi-car motor vehicle collision, large scale incident or an unexpected storm or other natural disaster. When this occurs, the 911 centers will call back any available dispatch personnel and may bring in secretaries, supervisors, police or other personnel to cover the business phones until the overload has been eliminated. In the day to day routine of the 911 center, overloads are uncommon.

***The Estimated Cost Of State-Of-The-Art Communication Technology Equipment For EMS Communications Within The Region***

Spokane County did a study during the last biennium which estimated approximately $30 million as the price tag for purchasing, installing and operating a "state of the art communications system "that meets future FCC narrowband requirements, in the county. A system cost for the region is not available at this writing.

Information developed by the Communications Committee to replace HEAR System equipment in all 19 hospitals in the region will cost approximately $325,000. The cost of the rest of the project has yet to be determined.

***Ability Of EMS Agencies To Communicate With Dispatch***

In this region EMS agencies contact dispatch centers on specific radio frequencies assigned to the dispatch center, or in some cases by telephone.

**Other System Status Information – Also See Disaster Preparedness Section**

The East Region Communications Committee has been tasked with developing a plan that will allow hospital to hospital communications, hospital to Regional Control Hospital (RCH) communications, and enhance communications between EMS and Medical Control (at the hospital).

The committee has spent three years studying various types of communications equipment and systems available within the state that would be compatible with the Project terrain of the region. The committee also wanted to ensure that equipment purchased would be FCC Project 25 compliant.

In a recent proposal to the Hospital Planning Committee and the Regional Council, the following plan was identified and approved:

**Phase I**

Purchase and installation of HEAR radio systems in East Region 9 (includes Columbia County) hospitals. Systems include:

- Dual transceiver/single transmitter VHF rack mount radios with variable power output settings as per FCC recommendations.
- Antenna and cable
- Desktop radio console
- Installation costs

Phase I will also include studies on Asotin, Ferry, Garfield, and Columbia counties to determine the best way for hospitals to communicate with the rest of East Region. 9. These studies will determine whether microwave, satellite and/or base stations will be needed in Phase III, and where they should be located. Approximate cost of this part of Phase I is $12,000.

**Phase II – Regional Control Hospitals (RCH)**

Regional Control Hospitals have been identified in this region. Deaconess Medical Center (DMC) in Spokane will provide primary Regional Control responsibilities and the Veterans Administration Medical Center (VA) will provide backup communications. Both of these hospital communications systems will be configured the same. These hospitals will have a base radio as described above and will control the base tower on Browns Mountain.

**Phase III – Connectivity**

This Phase will be determined by the studies identified in Phase I and the communications capabilities between Regional Control Hospitals and other hospitals in the region.

This project is a non-repeated communications net with Deaconess Medical Center **as** the Regional Control Hospital and the VA Hospital as secondary. EMS units, regional hospitals and trauma centers in the area will have the ability to communicate with DMC directly but not with each other (unless close to the transmitting unit/facility). DMC would receive transmissions and in turn retransmit the information to the intended receiving facility or process the information presented.

A system in conjunction with the satellite telephones and Amateur radio network installed through HRSA funding in all hospitals across the state, was needed to facilitate the communications needs of the region / state. The HEAR radio system is the most feasible and cost effective means in the region to communicate hospital to hospital. A need has been identified. A goal has been set. This proposal meets both an effective way of communication and a redundancy with back-up in place.

Total cost of this project is yet undetermined.

**2. Need Statement**

There are still 21% of dispatchers/call takers in this region that are not EMD trained to the regional standard.

HEAR System equipment in all 19 hospitals is 30-35 years old in some cases. Equipment needs to be replaced with current Project 25 HEAR equipment.

Communications studies need to be completed in Asotin, Garfield, Columbia and Ferry Counties to determine what type of microwave, satellite and/or base stations are needed to provide communications.

Connectivity needs to be completed between Regional Control Hospitals and Browns Mountain.

Connectivity needs to be completed in Asotin, Garfield, Columbia and Ferry Counties with Regional Control Hospitals.

**3. Goal 1: All Dispatchers Will Be Nationally Certified In Emergency Medical Dispatch**

**Objective 1**: ***Dispatch centers will certify all Dispatchers and call takers for all EMS dispatch agencies in Emergency Medical Dispatch (EMD) by 06/30/07.***

**Strategy 1:** Survey communication centers for EMD training needs annually.

**Strategy 2:** Host an EMD initial training class in Spokane if needed.

**Barrier:** Per NFPA Standard #6.3.2: "Communications centers that provide emergency medical dispatching (EMD) protocols shall have two telecommunicators on duty at all times.

**Goal 2: EMS agencies have access to statistical information from 911 centers.**

**Objective 1:** ***911 centers have the ability to track the time it takes for the 911 caller to contact a live person at the 911 center as well as provide statistical information regarding average times and numbers of calls to EMS agencies.***

**Strategy 1:** Poll 911 centers to determine how many have the capabilities identified in Objective 1 by June 2006.

**Goal 3: Communications in EMS incidents (hospital to hospital and prehospital to hospital) are reliable and well coordinated regardless of the number of patients or agencies involved.**

**Objective 1:** ***All hospitals will be able to talk with Regional Control Hospital(s) and EMS communications will be enhanced by June 2007.***

**Strategy 1:** The Hospital Planning Committee will list HEAR communications equipment on theirFY05 HRSA Priority Needs List seeking funding for Phase I – equipment purchase – by August 31, 2006.

**Strategy 2:** The Communications Committee will continue to work with the DOH and other appropriate organizations to complete communications studies in Asotin, Garfield, Columbia and Ferry Counties by August 31, 2006.

**Strategy 3:** The Communications Committee will work with the appropriate organizations in each identified area of the region to ensure agreements are in place for maintenance of the microwave, satellite or base stations necessary to complete Phase III by June 2007.

**Strategy 4:** The Communications Committee will seek outside funding for all Phases of the plan by June 2007.

| | |
|---|---|
| **Estimated System Cost - State of the Art Equipment** | |
| All of Spokane County | $30 million |
| Rural Counties | Unknown |
| **EMD Training – 911 Centers** | $16,200 |
| **Hospital to Hospital to EMS** | **$325,000** |
| **Phase I - HEAR Replacement Equipment only** | |
| **Phase I – 4 County Study** | **$12,000** |
| **Phase II and Phase III costs are unavailable** | |
| **Regional Council Cost** | |
| **EMD Training** | $2,000 |
| **Total Projected/Identified Costs** | **$30,355,200** |

**Barriers:** Funding availability for communications equipment and studies is the main barrier to updating communication needs.

9-1-1- Centers' ability to release staff to attend EMD classes is a problem as well the continuation of dispatcher turnover.

## B. Medical Direction of Prehospital Providers

### 1. System Status

***Current Status Of MPD Leadership Within The Region***

Leadership is provided on a county level by MPDs .Currently there are no MPDs on the Regional Council, or on any of the regional working committees. The Regional office provides correspondence to MPDs on a regular basis. They receive meeting notices and are specifically invited to attend the Annual Meeting. Generally one or two MPDs attend this meeting.

***Current Level Of Participation Of MPDs At The County And Regional System Levels***

Medical Program Directors are very active at the local EMS/TC council level. For example, they attend local council meetings, oversee the development and implementation of protocols, and provide Quality Improvement review of prehospital patient care runs. Again, there is no MPD involvement at the regional level.

The Spokane County MPD is very actively involved in the development and implementation of *EMS Live at Night* (a video conferencing training program) offered throughout the western United States. He is also very much involved in the development and implementation of the Pyramid Project, a medical disease surveillance program, in conjunction with Spokane Regional Health Department and major hospitals and infection disease specialists.

***Current Involvement Of The MPDs In PCP And COP Development***

MPDs take part in the review and /or updating of regional Patient Care Procedures (PCPs) and County Operating Procedures (COPS) on an annual basis when revisions are technical in scope.

### 2. Need Statement:

The Regional Council has tried for a number of years to find a way to get all nine MPDs together to attend a regional workshop, and have been unsuccessful. There are no MPDs on the Regional Council membership roster. Some local councils have a difficult time getting MPDs to attend meetings on a regular basis. The DOH has not been able to get all nine MPDs to attend the annual MPD meeting for the same reason that prehospital providers cannot travel outside of their response areas to seek education.

Rural counties have a difficult time getting physicians to live and work in their communities. If the community is lucky enough to have a physician who resides in the community, it is very likely that if he/she leaves the area, there will be no physician coverage. In some rural areas physician assistants are the norm. In the past, communities have had to share physician services with other rural communities. It wasn't to long ago that Asotin and Garfield Counties shared an MPD. Today all counties have an MPD even though not all rural towns have physicians that live and work in the community.

The Regional Council recognizes the need for active involvement from MPDs. There has been discussion at regional and state levels about how this could be accomplished. MPDs could attend meetings and be actively involved at the Regional level via video conferencing. The reported opinion among MPDs is that patient care is more important than attending meetings.

**3. Goals:**

**<u>Goal 1: Regional Council Membership Consists of at Least One MPD</u>.**

**Objective: Recruit at least one MPD to serve on the Regional Council by June 2007.**

**Strategy:** MPDs will be polled annually on why they are not participating in Regional Council functions and will be asked what alternatives could be put in place that would improve participation.

**Projected Costs**

| | |
|---|---|
| **Estimated System Costs MPD Travel Expense** | **$9720** |
| **Regional Council Costs** | $9720 |

**Barriers:** Getting all nine MPDs together in one place at the same time. Rural physicians are not always available because of patient needs and the lack of physician relief.

It is possible that there will not be an MPD who will agree to serve on the Regional Council.

## C. Prehospital EMS and Trauma Services

### 1. System Status

***Table C. Prehospital Providers by County and Level as of January 2005.***

**FFY04-05 Plan**

| County | FR | EMT | IV | AW | IV/AW | ILS | ILS/AW | PM | Totals | 2003 % Career | 2003% Volunteer |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Adams** | 1 | 56 | 0 | 0 | 0 | 1 | 1 | 0 | 59 | 17 | 83 |
| **Asotin** | 0 | 35 | 1 | 0 | 2 | 0 | 0 | 6 | 44 | 23 | 77 |
| **Ferry** | 1 | 42 | 0 | 0 | 0 | 3 | 1 | 0 | 47 | 2 | 98 |
| **Garfield** | 4 | 26 | 0 | 0 | 1 | 0 | 0 | 0 | 31 | 0 | 100 |
| **Lincoln** | 19 | 79 | 7 | 0 | 0 | 9 | 1 | 0 | 115 | 3 | 97 |
| **Pend Oreille** | 3 | 61 | 7 | 0 | 1 | 2 | 11 | 5 | 90 | 26 | 74 |
| **Spokane** | 115 | 1116 | 13 | 0 | 0 | 45 | 19 | 148 | 1456 | 54 | 46 |
| **Stevens** | 23 | 141 | 4 | 0 | 0 | 38 | 0 | 2 | 208 | 6 | 94 |
| **Whitman** | 44 | 157 | 4 | 0 | 5 | 9 | 7 | 7 | 233 | 15 | 85 |
| **Totals** | 210 | 1713 | 36 | 0 | 9 | 107 | 40 | 168 | 2283 | 16.2 | 83.8 |
| **Idaho*** | 0 | 22 | 21 | 0 | 1 | 0 | 0 | 18 | 62 | 84 | 16 |

**FFY06-07 Plan**

| County | FR | EMT | IV | AW | IV/AW | ILS | ILS/AW | PM | Totals | 2004% Career | 2004% Volunteer |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Adams** | 3 | 62 | 0 | 0 | 0 | 3 | 2 | 2 | 72 | 35 | 65 |
| **Asotin** | 0 | 30 | 0 | 0 | 1 | 0 | 9 | 6 | 46 | 17 | 83 |
| **Ferry** | 1 | 36 | 0 | 0 | 0 | 3 | 1 | 0 | 41 | 2 | 98 |
| **Garfield** | 4 | 22 | 0 | 0 | 1 | 0 | 0 | 0 | 27 | 0 | 100 |
| **Lincoln** | 20 | 87 | 8 | 0 | 0 | 10 | 1 | 0 | 126 | 5 | 95 |
| **Pend Oreille** | 2 | 55 | 6 | 0 | 1 | 2 | 9 | 6 | 81 | 32 | 68 |
| **Spokane** | 107 | 1090 | 13 | 0 | 1 | 53 | 26 | 154 | 1444 | 53 | 47 |
| **Stevens** | 12 | 169 | 4 | 0 | 0 | 35 | 3 | 1 | 224 | 6 | 94 |
| **Whitman** | 48 | 167 | 4 | 0 | 5 | 7 | 4 | 11 | 246 | 22 | 78 |
| **Totals** | 197 | 1718 | 35 | 0 | 9 | 113 | 55 | 180 | 2307 | 19.1 | 80.9 |
| **Idaho** | 0 | 26 | 20 | 0 | 1 | 0 | 1 | 19 | 67 | 85 | 15 |

*Idaho does not participate in training and other activities with the East Region and are therefore listed separately.

**Table C** above provides a comparison of the numbers and levels of prehospital providers by county within the region as well as the percentage of career and volunteer providers. Idaho, although listed, was not included in the percentages because they do not participate in East Region prehospital training.

According to the information provided by the DOH in Table C, the percent of career providers has increased by 2.9% in the last few years. The 2006-07 numbers also reflect an increase of 24 providers within the region from the 2004-05 plan.

**Describe The System Roles Of The Additional Public Safety Personnel And Other Groups That Augment The EMS And Trauma System.**

Entities involved in public safety as it relates to the EMS and trauma system are: Washington State Patrol, Sheriff's Departments, Fairchild AFB, Air National Guard, Emergency Management, Public Health, American Red Cross, Rural Health, Civil Air Patrol, and other military squadrons at Fairchild AFB, the Army Guard & Reserves and the Reserve Unit out of Camp Murray. Public safety personnel attend the EMT-Basic courses offered in the East Region on a routine basis. EMS and trauma care provider's work hand in hand with law enforcement search and rescue and also utilize military resources, as it is appropriate.

**Other System Status Information at the Discretion of the RC**

***EMS Live at Night***

Inland Northwest Health Services (INHS) continues to broaden its base for using TeleHealth in this region. The current *EMS Live at Night* training program offered over TeleHealth (video conferencing) and collaboratively developed by Spokane County and INHS has recently been awarded a $300,000 3-year grant to enhance and expand the program. The grant includes all of eastern Washington and parts of western Washington, Idaho, Alaska, Oregon and Montana. Some states have authorized the use of *EMS Live at Night* for CME certification requirements. In East Region Whitman, Spokane, Ferry, Pend Oreille and Adams County MPDs have approved *EMS Live at Night* for CME. For many rural EMS providers, attending *EMS Life at Night* requires travel which in many instances would leave their response area without EMS coverage.

Training through video conferencing is not as accessible to all EMS providers in this region as is desirable. Each of the trauma-designated facilities has video conferencing capabilities and has opened their doors to the video conferencing technology. The problem is that there are still EMS providers that would need to travel outside of their response areas to receive this kind of training. Traveling outside of response areas will in many instances leave an area without EMS coverage. INHS is aware of the problem.

***Inland Empire Training Council – Mobile Training Van***

The Inland Empire EMS Training Council (IETC – Training Council) was established in the early 1990's and operates the Mobile Training Van (MTV) that provides training throughout the East Region. This program enjoys an outstanding reputation throughout the nine counties. The focus of the MTV is to provide Community Based Continuing Medical Education through the regions Ongoing Training & Education Program (OTEP) to rural volunteer/paid providers using this delivery method to provide convenience and accessibility. Rural BLS volunteers are the target audience. Current records indicate that the number of miles traveled by East Region providers to educational classes is 4.6 miles.

The Regional Council contracted with the Training Council to develop an ILS/ALS OTEP that will be available regionwide. The program has been reviewed by the DOH and will be presented to the Regional Council for review in April 2005 with plans for implementation no later than September 2005.

Although PHTLS is still a very viable training course for rural prehospital EMS volunteer

providers in East Region because of the intensity of the course study, it is also very expensive. Approximately 50-70 students can receive training at one time which is the highest attended course offered by the Training Council to EMS providers. The Training & Education Committee has forwarded a recommendation to the Inland Empire Training Council's Board of Directors that a $35 registration fee be charged to all students for this class. Recent survey results indicate that providers are willing to contribute to the cost of the class rather than lose this course.

The American Academy of Pediatrics has rolled out a new pediatric course designed specifically for pre-hospital providers (PEPP). The course is being provided regionwide at least one to two times per year.

In addition to providing education for the pre-hospital EMS/TC provider, the Training Council offers instructor education to increase the quality and availability of pre-hospital educators. In order to be cost effective, instructor education is offered jointly to the East/North Central Region instructors.

***Other Training Resources***

- The East Region Training & Education Committee in preparing for a 2006 EMS Conference to be held March 16 and 17, 2006 at the Ridpath Hotel in Spokane.

- Hospital based training for advanced care providers such as ACLS and Pals.

- Northwest MedStar makes available CME training to all EMS providers upon request.

- Deer Park Ambulance has recently started a Regional Training Center which will provide training to southern Stevens County and northern Spokane County.

- Numerous individuals provide initial training classes for FR, EMT and EMT-I certification.

**2. Need Statement**

***Recruitment and Retention of EMS Providers***

The information provided by the DOH in Table C indicates that there are more certified EMS providers in the region now than there were 2 years ago. Increases in EMS providers, although minimal, are in Adams, Asotin, Lincoln, Stevens and Whitman Counties. Generally the small rural communities such as Ferry and Garfield find it difficult to replace EMS providers due to geography, economics and/or age of residents. As illustrated in Table C, you will note a decrease in providers in those counties since the 2004-05 Plan.

### *Initial Provider Training and Ongoing Training and Education (OTEP)*

The Regional Council provides 47% its DOH-EMSTS contractual funds to rural prehospital EMS and trauma training annually through its contract with the Inland Empire Training Council (Mobile Training Van). Ongoing education and training needs assessments continue to support contracting for BLS OTEP classes and other continuing education courses. For the Regional Council to provide additional training to enhance skill knowledge using its current training model, outside funding must be acquired. Although a Regional ILS/ALS OTEP has been developed, it may be difficult to implement due to lack of funding. Discussions between the Training & Education Committee and the Training Council are ongoing in this area.

### Distance Learning

The Training & Education Committee is looking at various other resources available for distance learning. These programs would include an online Computer Based Training (CBT) and options better that include live broadcasting of OTEP modules followed by recorded versions mailed out to agencies who do not have the TeleHealth capabilities, individuals who may have missed that particular training or want to review that same training and those who may not have the financial resources for TeleHealth or internet connections. There are a host of activities that can be incorporated into what is currently in place that can add to, take the place of, dramatically increase the efficiency of delivered training and most importantly of all, enhance the overall quality of rural training.

Although most of the prehospital agencies in the region have computers at their stations, many areas of the region do not provide high speed Internet connections. In some instances, distance learning via dial up Internet connection is not practical. EMS providers may have access to a computer if there is a library in their community. Not all communities have libraries and not all libraries have the funding to provide computer access.

The committee is developing a program geared toward some of the didactic sections of the OTEP classes through some of these ideas. INHS and the Inland Empire Training Council along with the committee are discussing the possibilities of this type of training.

### Initial Training

In addition to the ongoing continuing education classes there is a need for initial FR EMT EMT-I and PM training which require funding outside of the Regional Council. EMS agencies throughout the region are encouraged to submit grants for funding of initial classes through the DOH Prehospital Needs Grant Program. Spokane Community College (SCC) is currently the only college in the East Region offering an EMT course curriculum at a cost of approximately $650 per student. SCC also offers the only Paramedic course in Eastern Washington.

### Changing Regional Boundaries

There is discussion at the state level about changing EMS regions to those of public health. If that happens, the East Region will add Columbia County to its already geographically large region and expenses will continue to increase. According to the Office of Financial Management population growth in the East Region in the past 13 years has an increase of approximately 83,000 people. The continued growth in population increases the need for EMS providers and training.

***Instructor Pool***

The new requirements for EMS/EMT instructors have brought new challenges for their certification and recertification. The most pressing challenge at this point seems to be certification requirements. A recent survey identified that 66% of SEIs that needed to recertify in 2004 did not do so. 33% of SEIs due to recertify in 2005 have indicated they do not plan to recertify. When asked in the survey why certification was not being renewed, 7 out of 12 instructors stated that it was just too difficult to keep up with the DOH requirements. As instructors decrease student cost increases due to extra travel expenses.

***Opportunities for Skill Maintenance***

There is a need for additional skills maintenance opportunities throughout the region. Rural hospitals don't have a high volume of patients to provide skills maintenance to EMS providers. Dedicated staff is not available at regional hospitals to oversee EMS provider skills. There is a medical reluctance by hospitals to participate in skill maintenance due to medical liability issues. MPDs, physician advisors, agency management providers work closely with hospitals to try to arrange for skills maintenance of tubes and IV sticks while at the same time competing with hospital staff, nursing students, physicians in training and others for those limited opportunities. Limited skills maintenance is provided through BLS, ILS, ALS OTEP as well as PHTLS, GEMS and PPE classes.

***Training/Education Aids and Equipment***

The following training and education aids and equipment have been identified by providers in the regions as being needed to support their education efforts:

- Laptop computer with video projector
- VCR/DVD/TV, Whiteboards, PowerPoint Software
- CD Rom training aids
- Up-to-date videos
- Rhythm Generators
- Manikins
- ALS & IV Trainers;
    - adult, junior and infant CPR (preferable shock-able and tube-able);
    - Airway, IV, OB, IO;
    - IV arms'
        - EMT class equipment for 12-lead and full size simulators, anatomical models simulation kit for moulage
        - Needles, IVs. Combitubes, glucose meter etc.

***Basic and State-Of-The-Art Emergency Medical Care Equipment***

In order for prehospital providers to continue to provide excellent patient care, licensed and verified services need the necessary equipment to enhance their services. In a recent survey nearly all rural volunteer prehospital licensed and verified agencies identified needs for:

1) trauma equipment
2) medical equipment
3) communications equipment such as but not limited to radios, repeaters and base stations as well as pagers, cell phones and GPS devices

4) training equipment; and
5) extrication equipment and extrication training.

Specific items identified include but are not limited to:

- Cardiac monitoring equipment
- Airway support equipment
- Extrication equipment
- Communications equipment
- Trauma care equipment
- Medical equipment
- Personal protective equipment (PPE)

## 3. Goals

**Goal 1: Prehospital EMS/TC Training Is Provided Regionwide.**

**Objective 1:** ***ILS/ALS OTEP will be implemented Regionwide by 12/2005.***

**Strategy 1:** By December 31, 2005 work with the Training Council to identify funding sources for ILS/ALS OTEP.

**Objective 2:** ***By June of each year in the biennium Training & Education Committee will work to identify a means to maximize the number of classes/students that can be offered in the rural areas of the region in the annual Regional Council training contract.***

**Strategy 1:** Contract for prehospital provider training annually in 6/2006 and 6/2007. Contract language will be specific to numbers of classes/students to be trained during the year.

**Strategy 2:** The Training & Education Committee, in conjunction with the Inland Empire Training Council, will pursue the possibility of providing distance learning to EMS providers by increasing the efficiency of delivered CME and OTEP classes by June 2007.

**Objective 3:** ***Maintain* or *increase the number of EMS/EMT instructors within the rural areas of the region by 6/30/06.***

**Strategy 1:** The Training & Education Committee will work with the Inland Empire Training Council to host the DOT class, annually and/or biennially if needed.

**Objective 4:** ***Pursue the development of BLS, ILS and paramedic initial training programs regionwide by asking county EMS/TC councils to recommend agency participation in the Prehospital Needs Grant Program by June 2006.***

**Strategy 1:** Encourage agencies to seek funding for BLS, ILS and ALS initial training through the DOH, Prehospital Needs Grant Program during FY 06 and assist them as possible.

**Strategy 2**: A database of all initial classes authorized by the DOH will be continually updated and information will be provided to the Training & Education Committee for review in June of 2006 and 2007.

**Objective 5:** ***Continue to Improve the Mobile Training Van Service by distributing a survey to all EMS agencies on training & education needs by June 2006.***

**Strategy 1:** The Training & Education Committee will distribute to all EMS agencies Regionwide, by June 30, 2006, a training survey which will be used to assess training needs (aids, equipment and training) as well as to provide review of the Inland Empire Training Council. The results of the survey will be used to update the 2008-09 biennial plan.

**Objective 6:** ***Ensure that education and training programs reflect recent and upcoming regulatory and curriculum changes by asking the Director (or designee) of the Inland Empire Training Council to serve as a technical advisor on the Training & Education Committee and to report on any updates at bi-monthly meetings.***

**Strategy 1:** The Training & Education Committee will insert verbiage into its training contract that will require said contractor to provide updates on regulatory and curriculum changes to committee members and prehospital agencies/providers as available. Completion date will be 6/2005 and 6/2006.

**Objective 7:** ***Support existing programs and conduct additional training programs to expand BLS capabilities throughout the region by reviewing the current OTEP to determine if course modules need rotation or updating by June 2007.***

**Strategy 1:** Regional OTEP will be updated upon recommendation by the Training & Education Committee or as required by the DOH by 6/2007.

**Project Costs - Biennium**

| | |
|---|---|
| **Estimated System Costs** | **$3,420,000** |
| **Regional Council Costs** | **$ 120,000** |

**Barriers:** There may be a need for the DOT Instructor class, however actually hosting the class will be dependent upon registration.

There is never really enough funding to provide the education needed to train and keep certified the volunteer EMS providers. Funds are being stretched to the limit.

## D. Verified Aid and Ambulance Services:

### 1. System Status

***Table D. Approved Min/Max numbers of Verified Trauma Services by Level and Type by County***

***NOTE: There are NO changes to the min/max numbers at this time. Recommendations will be made in the future, but are not included with this plan.***

| County (Name) | Verified Service Type | State Approved - *Minimum number* | State Approved - *Maximum number* | Current Status (# Verified for each Service Type) |
|---|---|---|---|---|
| ***Adams*** | Aid – BLS | 0 | 0 | 0 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 2 | 2 | 2 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 0 | 0 | 0 |
| ***Asotin*** | Aid – BLS | 1 | 1 | 1 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 0 | 0 | 0 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 1 | 1 | 1 (Idaho) |
| ***Ferry*** | Aid – BLS | 0 | 0 | 0 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 2 | 2 | 2 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 0 | 0 | 0 |
| ***Garfield*** | Aid – BLS | 0 | 0 | 0 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 1 | 1 | 1 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 0 | 0 | 0 |
| ***Lincoln*** | Aid – BLS | 2 | 2 | 2 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 6 | 6 | 6 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 0 | 0 | 0 |
| ***Pend Oreille*** | Aid – BLS | 6 | 7 | 7 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 2 | 3 | 3 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 0 | 0 | 0 |

| County (Name) | Verified Service Type | State Approved - *Minimum number* | State Approved - *Maximum number* | Current Status (# Verified for each Service Type) |
|---|---|---|---|---|
| ***Spokane*** | Aid – BLS | 13 | 13 | 13 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 3 | 3 | 3 |
| | Amb –BLS | 1 | 1 | 1 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 2 | 2 | 2 |
| ***Stevens*** | Aid – BLS | 5 | 8 | 3 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 3 | 4 | 3 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 1 | 1 | 0 |
| ***Whitman*** | Aid – BLS | 10 | 13 | 11 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 8 | 13 | 6 |
| | Amb – ILS | 1 | 5 | 0 |
| | Amb - ALS | 1 | 1 | 1 |

**Regional Process For Determining Need And Distribution Of Verified Trauma Care Services.**

Guidelines for developing the Need and Distribution of Services are provided by the DOH. These guidelines are distributed to each agency and county EMS/TC council. The need for the development of these documents is a deliverable in agreements between the county and regional EMS/TC councils. A review schedule is developed and provided to each county. County councils work with their agencies to ensure accuracy in the document. The documents are then presented to the Prehospital and Transportation Committee for review and recommendation to the Regional Council, which then adopts the document and submits it to the DOH for review and approval. The council then uses the information in these narrative documents to produce the Plan.

Currently Asotin and Pend Oreille County documents have not been reviewed according to the approved process. Response area maps and Table C in this section have been completed by all nine counties. Upon receipt Asotin and Pend Oreille County documents will go through the approved process.

Adams, Ferry, Garfield, Lincoln, Spokane, Stevens and Whitman County documents have been reviewed. There are no changes to the Adams, Ferry, Garfield and Lincoln County Need and Distribution of Services. Changes to min/max recommendations from Spokane, Stevens, Whitman, Pend Oreille and Asotin Counties will be submitted under separate cover.

Trauma Response Area Maps by County can be found in Exhibit 1.

## *Table E. Trauma Response Areas by County*

| County Name | Trauma Response Area # | Description | Type of Verified Services in each area |
|---|---|---|---|
| **Adams**<br><br>Othello | <br><br>#1. (Yellow) | Approximately 288 square miles in the SW corner of Adams County, bordered by Grant and Franklin Counties – From Providence Rd to Hy 24 and Byers Rd to Roxboro Rd. Currently Othello Ambulance covers this response area. | D-1 |
| Ritzville | #2. (Gold) | Approximately 558 square miles in the N.E. corner of Adams County, from Dewald Rd to Widgeon Lake and from Dewald Rd. to Zornes Rd. Ritzville is also bordered by Lincoln and Whitman Counties. This response area is covered by Ritzville. | D-1 |
| Mutual Aid | #5 Green Black | Currently Sprague also covers this response area with Ritzville via Mutual Aid. | D-1 |
| Washtucna | #3. (Orange) | Approximately 571 square miles in the S.E. corner of Adams County, from Dewald Rd. to Zornes Rd. and from Dewald Rd. to Beckley Rd. on Highway 26. Washtucna is also bordered by Franklin and Whitman Counties. This response area is currently covered by Washtucna. | D-1 |
| Auto Response | #5 (Green Black) | Currently Odessa also covers parts of Washtucna | D-1 |
| Lind | #4. (Gray) | Approximately 717 square miles in Central Adams County, is bordered by Othello Community Hospital Ambulance Service and Washtucna Ambulance Service. Response from Roxboro Rd. to Dewald road. Lind is also bordered by Franklin and Lincoln Counties. This response area is currently covered by Lind. | D-1 |
| **Asotin** | #1 | All of Asotin County | B-1<br>F-1 |
| **Ferry** | #1 C-1 | Approximately 200 square miles located in the northwest corner of the county. Bordered on the north by the US/Canada boundary, on the south by the EMS District #1 response area, on the east by the Kettle Crest trail, and on the west by the Ferry County/Okanogan County line with the exception of 2200 acres annexed into FY/OK FPD#14. See map for details. Currently North Ferry County Ambulance/Ferry/Okanogan Fire Protection District #14 covers this response area. | D-2 |
| | #2 R-1 | Approximately 300 square miles located in the western portion of the county. Bordered on the north by Ferry//Okanogan FPD !24 boundary, on the south by the Colville tribal response area, on the east by Albian Hill Road (see map), and on the west by the Ferry County/Okanogan County line with the exception of a corridor along Highway 20 West and extending to Wauconda. Currently Ferry County EMS District #1 covers this area. Extrication is available in this response area. | D-4, |
| **Garfield** | 1 | All of -Garfield County | A1<br>D1 |

**Key: For each level the type and number should be indicated**

| | |
|---|---|
| Aid-BLS = A | Ambulance-BLS = D |
| Aid-ILS = B | Ambulance-ILS = E |
| Aid-ALS = C | Ambulance-ALS = F |

| County Name | Trauma Response Area # | Description | Type of Verified Services in each area |
|---|---|---|---|
| **Lincoln** | 1. 640 | 14 square miles located in the extreme northwest corner of the county adjacent to the Lincoln/Grant county line. Currently Grand Coulee Fire and EMS covers this area | A-1<br>D-1 |
| | 2. 641 | 17 square miles located in the extreme northwest corner of the county along Lake Roosevelt. Currently Grand Coulee Fire and EMS covers this area, | A-3<br>D-2 |
| | 3. 643 | 288 square miles located in the central portion of the northwest quarter of the county, centered around the Town of Wilbur. Currently Wilbur Fire and EMS covers this area. | A-1<br>D-1 |
| | 4. 644 | 200 square miles located in the eastern portion of the northwest quarter of the county, centered on the Town of Creston. Currently Creston Fire and EMS covers this area. | A-1<br>D-1 |
| | 5. 645 | 22 square miles located in the northwestern corner of the northeast quarter of the county, adjacent to Lake Roosevelt and centered on the Seven Bays community. Currently Seven Bays Fire and Davenport EMS cover this area. | D-1 |
| | 6. 647 | 58 square miles located in the north central portion of the northeast quarter of the county adjacent to Lake Roosevelt. Currently Egypt Fire and Davenport EMS cover this area. | D-1 |
| | 7. 648 | 14 square miles located in the extreme northeast corner of the county adjacent to the Spokane River and Lincoln/Stevens county line. Currently Long Lake and Reardan Fire and Wellpinit Ambulance and Davenport Ambulance cover this area. | A-2<br>D-2 |
| | 8. 649 | 174 square miles located on the Lincoln/Grant county line of the western edge of the northwest quarter of the county centered on the Town of Almira. Currently Almira Fire and EMS and Wilbur EMS cover this area. | A-1<br>D-1 |
| | 9. 650 | City limits of the Town of Wilbur Currently Wilbur Fire and EMS covers this area. | A-1<br>D-1 |
| | 10. 651 | City limits of the Town of Creston Currently Creston Fire and EMS covers this Area. | D-1 |
| | 11. 652 | 283 square miles located in the southwest portion of the northeast quarter of the county centered on the City of Davenport. Currently Davenport Fire and Davenport Ambulance cover this area. | D-1 |
| | 12. 653 | 36 square miles located in the northern portion of the eastern third of the northeast quarter of the county, bordering the Lincoln/Spokane County line. Currently Long Lake and Reardan Fire and EMS and Davenport Ambulance cover this area. | A-2<br>D-1 |
| | 13. 654 | City limits of the Town of Almira, Currently Almira Fire and EMS and Wilbur EMS covers this area. | A-1<br>D-1 |
| | 14. 655 | City limits of the City of Davenport. Currently Davenport Fire and Davenport Ambulance cover this area. | D-1 |
| | 15. 656 | 107 square mites located in the eastern third of the northeast quarter of the county centered on the Town of Reardan. Currently Reardan Fire and EMS and Davenport Ambulance cover this area. | A-1<br>D-1 |
| | 16. 657 | City limits of the Town of Reardan. Currently Reardan Fire and EMS and Davenport Ambulance covers this Area. | A-1<br>D-1 |
| | 17. 658 | 507 square miles located in the southwest quarter of the county adjacent to the Grant/Lincoln County line and the Lincoln/Adams county line. Currently Odessa Fire and EMS covers this area. | D-1 |

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Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

| County Name | Trauma Response Area # | Description | Type of Verified Services in each area |
|---|---|---|---|
| **Lincoln** | 18. 659 | 283 square miles located in the south central portion of the county centered on the Town of Harrington and extending towards the Adams/lincoln county line. Currently Harrington Fire and EMS covers this area. | A-1<br>D-1 |
| | 19. 660 | City limits of the City of Harrington. Currently Harrington Fire and EMS covers this area. | A-1<br>D-1 |
| | 20. 661 | 94 square miles located in the eastern central portion of the county adjacent ot the Lincoln/Spokane county line centered on the community of Edwall. Currently Edwall Fire and EMS and Davenport Ambulance cover this area. | A-1<br>D-1 |
| | 21. 62 | 20 square miles located in the south eastern central portion of the county adjacent to the Spokane/Lincoln county line. Currently Edwall Fire and EMS and Sprague Ambulance cover this area. | A-1<br>D-1 |
| | 22. 663 | City limits of the Town of Odessa. Currently Odessa Fire and EMS covers this area. | D-1 |
| | 23. 664 | 296 square miles of the southeastern quarter of the county adjacent to the Spokane/Whitman/Adams/Lincoln county line including a portion of I-90 through the county. Currently Sprague Fire and EMS covers this area. | A-1<br>D-1 |
| | 24. 665 | 21 square miles located in the extreme south central area of the county along the Adams/Lincoln county line. Currently Adams County Fire and Ritzville EMS cover this area. | A-1<br>D-1 |
| | 25. 666 | City limits of the Town of Sprague. Currently Sprague Fire and EMS covers this area. | A-1<br>D-1 |

| | | | |
|---|---|---|---|
| **Pend Oreille** | Zone 1 | Incorporates 2 towns & all areas of the county between MM 405 on Hwy 20 south to Fertile Valley Rd on Hwy 2. Includes Fire Districts 3, 4, 5, 6, 7 8. Currently Newport Ambulance provides coverage and provides tiered response for ALS. | A-5<br>D-1 |
| | Zone 2 | Incorporates 3 towns and all areas of the county north of MM 405 to the US Border. Currently ambulance coverage is provided by District 2 which has limited ALS. | A-1<br>D-2 |
| | Fire District 2 | Fire District 2 covers north Pend Oreille County and excludes the towns of Ione, Metaline and Metaline Falls. Size 750 square miles. | A-1<br>D-2 |
| | Fire District 3 | District 3 rests in the southern center portion of the county and has 2 main highways. Size is 100 sq. Miles. | A-3<br>D-1 |
| | Fire District 4 | District 4 rests in the mid portion of the county around the town of Cusick. Size is 95 sq. miles. By contract it covers the Kalispell Reservation. It has 2 state highways. | A-3<br>D-1 |
| | Fire District 5 | District 5 starts approximately 3 miles north of Cusick and extends northward through the middle of the county to Fire District 2. Size 60 sq miles. | A-2<br>D-2 |
| | Fire District 6 | District 6 rests between the east bank of the Pend Oreille River and Idaho. It extends from Newport to Usk. Size 75 sq. miles. | A-2<br>D-1 |
| | Fire District 7 | District 7 is located in the southwest corner of the county. It has one state Hwy. Size 18 sq. miles | A-2<br>D-1 |
| | Fire District 8 | District 8 is located at the south border of the county bordered by Idaho & Spokane County. District 8 has no Aid Service. Currently FD #3 provides Aid by Mutual Aid. Size 29 sq. miles. | A-1<br>D-1 |

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Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

| County Name | Trauma Response Area # | Description | Type of Verified Services in each area |
|---|---|---|---|
| **Spokane** | 1 | 101,700 sq miles located in the east area of Spokane County and currently covered by SCFD #1 | C-1<br>F-1 |
| | 2 | 132.5 sq miles located in southeast Spokane County and currently covered by SCFD #2 | A-1<br>D-1<br>F-1 |
| | 3 | 565 sq miles located in southwest Spokane County and currently covered by SCFD #3 | C-1<br>F-1 |
| | 4 | 330 sq miles located in north Spokane County and currently covered by SCFD #4 (Corrected 9/18/2006 from C-1 to B-1) | B-1<br>F-2 |
| | 5 | 88 sq miles located in southeast Spokane County and currently covered by SCFD #5 | C-1<br>F-1 |
| | 6 | 60 sq miles located in the center of Spokane County and currently covered by Spokane City FD | C-1<br>F-1 |
| | 7 | 5.5 sq miles located in the east Spokane County and currently covered by Airway Heights FD | A-1<br>F-1 |
| | 8 | 110 sq miles located in southeast Spokane County and currently covered by SCFD #8 | C-1<br>F-1 |
| | 9 | 130 sq miles located in the north area of Spokane County and currently covered by SCFD #9 | A-1<br>F-1 |
| | 10 | 95 sq miles located in east Spokane County and currently covered by SCFD #10 | A-1<br>F-1 |
| | 11 | 71 sq miles located in the southeast section of Spokane County and currently covered by SCFD #11 | A-1<br>F-1 |
| | 12 | 79 sq miles located in the south area of Spokane County and currently covered by SCFD #12 | A-1<br>F-1 |
| | 13 | 22 sq miles located in the Newman Lake area in northeast area of Spokane County and currently covered by SCFD #13 | A-1<br>F-1 |
| | 14 | 4.3 sq miles located in the southeast Spokane County and currently covered by the Medical Lake FD | A-1<br>F-1 |
| | 15 | 4.5 sq miles located south of Spokane County and currently covered by the Cheney FD | A-1<br>F-1 |
| | 16 | This the Spokane Inter-national Airport in the area east of Spokane County and currently covered by the Spokane International Airport FD | A-3<br>F-1 |
| **Stevens** | #1 | 36 square miles in the northwest corner of Stevens County. Current geographical boundaries of Fire District #8 | A-1<br>D-1 |
| | #2 | 375 square miles in the northeast corner of Stevens County | A-1<br>D-1 |
| | #3 | 150 square miles between Trauma Response areas #1 and #2, the southern border being Lake Roosevelt. | D-1 |
| | #4 | 625 square miles south of Trauma Response areas #1, #2 and #3. North of Trauma Response areas #4 and #5. | D-1 |
| | #5 | 70 square miles in west central Stevens County. Current geographical boundaries of Fire District #12. | A-1<br>D-1 |
| | #6 | 550 square miles in central Stevens County. South of Trauma Response area #4 and east of Trauma Response area #5. | D-1 |
| | #7 | 240 square miles in southwestern Stevens county. Current geographical boundaries of the Spokane Indian Reservation. | D-1 |

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| | |
|---|---|
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| County Name | Trauma Response Area # | Description | Type of Verified Services in each area |
|---|---|---|---|
| **Whitman** | #8 | 375 square miles in southeastern Stevens County. Current geographical boundaries of Fire District #1. | A-1<br>D-1<br>F-1 |
| | 3801 | 107.6 square miles located in the northwest corner of the county adjacent to Spokane/Adams county lines. Currently within the coverage area of Lamont Fire dept. and Sprague Ambulance | A-1<br>D-1 |
| | 3802 | 206.1 square miles located west of SR195 and includes the towns of Ewan, St. John, Sunset, and Pine City. Currently within the coverage area of St. John Fire Dept. and Rosalia Fire Dept. | A-1<br>D-1 |
| | 3803 | 49.5 square miles located south of St. John. Currently within the coverage area of St. John Fire Dept. and Colfax Ambulance | A-1<br>D-1 |
| | 3804 | 189.0 square miles located west of Colfax and includes the towns of Winona and Endicott. The west end of this area ends at the Adams county line. Currently within the coverage area of Endicott Fire Dept. and Colfax Ambulance | A-1<br>D-1 |
| | 3805 | 0.75 square miles located within the city limits of Malden. Currently within the coverage area of Malden Fire Dept. and Rosalia Ambulance | A-1<br>D-1 |
| | 3806 | 430.4 square miles located in the southwest portion of the county. Currently covered by LaCrosse Fire Dept. and Colfax Ambulance service. All currently within the coverage area of Washtucna Ambulance | A-1<br>D-1 |
| | 3807 | 62.3 square mile area around the town of Palouse on the eastern border of the county. Currently within the coverage area of Palouse EMS provides BLS Aid and Pullman Fire Dept. | A-1<br>F-1 |
| | 3808 | 5.8 square mile area in the center portion of the county with limited accessibility. Currently within the coverage area of Diamond & St. John Fire Depts. | A-1<br>D-1 |
| | 3809 | 10.5 square mile area in the northeastern portion of the county. Farmington Currently within the coverage area of Tekoa Ambulance | A-1<br>D-1 |
| | 3810 | 62.4 square mile area in the extreme northeastern corner of the county including the town of Tekoa. Currently within the coverage area of Tekoa Ambulance. | D-1 |
| | 3811 | 94.1 square mile area located on the eastern portion of the county including the towns of Garfield and Farmington. Currently within the coverage area of Farmington Fire & EMS and Garfield Ambulance | A-1<br>D-1 |
| | 3812 | 0.3 square mile area between 3807 and 3811. Currently within the coverage area of Palouse EMS and Garfield Ambulance | A-1<br>D-1 |
| | 3813 | 61.9 square miles in the center portion of the county where SR 23 and SR 195 intersect. Currently within the coverage area of Steptoe Fire Dept. and Colfax Ambulance | A-1<br>D-1 |
| | 3814 | 68.7 square miles located in the northeastern corner of the county including the town of Oakesdale. Currently within the coverage area of Oakesdale Fire Dept. and Rosalia Fire Dept. | A-1<br>D-1 |
| | 3815 | 121.6 square mile area located in the northern center portion of the county along the Spokane County line including the town of Rosalia and outside the city limits of Malden. Currently within the coverage area of Rosalia Fire Dept | D-1 |
| | 3816 | 56.7 square mile area west of Colfax and north of SR 26. Currently within the coverage area of Diamond Fire Dept. and Colfax Ambulance | A-1<br>D-1 |

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| | |
|---|---|
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| Aid-ILS = B | Ambulance-ILS = E |
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| County Name | Trauma Response Area # | Description | Type of Verified Services in each area |
|---|---|---|---|
| **Whitman** | 3817 | 185.7 square mile area around the town of Colfax and extending along the south side of SR 26. Currently within the coverage area of Colfax Ambulance. | D-1 |
| | 3818 | 1.0 square mile area between TRA 3813 and 3811. Currently within the coverage area of Steptoe Fire Dept. and Garfield Ambulance | A-1<br>D-1 |
| | 3819 | 26.7 square mile area north of TRA 3813. Currently within the coverage area of Steptoe Fire Dept. and Rosalia Fire Dept. provides BLS Ambulance | A-1<br>D-1 |
| | 3820 | 56.7 square mile area in and around the town of Albion. Currently within the coverage area of Albion Ambulance. | D-1<br>F-1 |
| | 3821 | 19.5 square mile area between TRA 3804 and 3816. Currently within the coverage area of Endicott and Diamond Fire Depts. | A-2<br>D-1 |
| | 3822 | 3.0 square mile area outside the southwestern corner of TRA 3811. Currently within the coverage area of Garfield Ambulance | D-1 |
| | 3823 | 12.5 square mile area outside the northwestern corner of TRA 3811. Currently within the coverage area of Oakesdale Fire Dept. and Garfield Ambulance | A-1<br>D-1 |
| | 3824 | 4.0 square mile area outside the southwestern portion of TRA 3810. Currently within the coverage area of Oakesdale Fire Dept. and Tekoa Ambulance | A-1<br>D-1 |
| | 3825 | 171.9 square mile area in the southeastern portion of the county around the city of Pullman. Currently in the coverage area of Fire District 12 and Pullman Fire | A-1<br>F-1 |
| | 3826 | 3.7 square mile area within the city limits of Pullman. Currently in the coverage area of Pullman Fire. | F-1 |
| | 3827 | 157.7 square mile area in the extreme southeastern portion of the county including the towns of Colton and Uniontown. Currently in the coverage area of Colton/Uniontown Fire Dept. and Lewiston Ambulance | A-1<br>F-1 |
| | 3828 | 2.4 square mile area within the Washington State University Campus. Currently within the coverage area of WSU Fire Services and Pullman Fire Services | D-1<br>F-1 |
| | 3829 | 2.3 square mile area north and east of TRA 3828. Currently within the coverage area of WSU Fire Services and Pullman Fire Services | D-1<br>F-1 |
| | 3830 | 1.6 square mile area within the city limits of Colfax. Currently within the coverage area of Colfax Fire Dept. and Colfax Ambulance | A-1<br>D-1 |

Key: For each level the type and number should be indicated

| | |
|---|---|
| Aid-BLS = A | Ambulance-BLS = D |
| Aid-ILS = B | Ambulance-ILS = E |
| Aid-ALS = C | Ambulance-ALS = F |

**2. Need Statement:**

***Identify Needs Within The Region Related To Verified Trauma Services***

Currently all 68 licensed agencies are verified. There is an existing need to get timely information from Local Councils about their county systems for ongoing regional planning. There is a need to change the min/max numbers of verified ambulance services in Spokane, Stevens, Asotin, Pend Oreille & Whitman Counties for various reasons. Millwood Fire Department in Spokane Valley was absorbed by Spokane Valley Fire Department making one less BLS agency in Spokane County. Clarkston Fire Department in Asotin County plans to upgrade to an ALS Aid service in the near future. Stevens, Pend Oreille and Whitman Counties changed their min/max recommendations in the last plan expecting agencies to upgrade their verification status. All three counties now realize another level of service is not going to happen, hence a need to reevaluate the min/max recommendations. Proposals for change to min/max numbers for verified agencies will be submitted under separate cover when complete.

**Goal 1: County Specific Needs and Distribution of Services Documents shall remain current.**

**Objective 1:** ***The Prehospital & Transportation Committee and the Regional Council will know the status and future needs of each prehospital agency within the region by requesting 100 percent of the information needed, in the time provided, on surveys and other methods of inquiry during each year.***

**Strategy 1:** The Council will work with the Local Councils in FY 06 and FY 07to identify the barriers to getting timely and complete responses to regional requests for information and develop methods that improve results.

**Strategy 2:** The Prehospital & Transportation Committee will work with county EMS/TC Councils to review and update the Needs and Distribution of Services documents by December 2006.

**Strategy 3**: The Prehospital & Transportation Committee will provide technical assistance to any county EMS/TC council or prehospital agency seeking initial verification or change in current verification status as needed.

**Projected Costs - Biennium**

| | |
|---|---|
| **Estimated System Costs** | **$7.5 million** |
| **Regional Council Cost (Travel costs)** | **$ 5,000** |

**Barriers:** With a region consisting of nine counties it is sometimes difficult to get all counties to participate in projects necessary for planning. Examples include surveys, county specific input to the EMS & Trauma Plan, etc.

## E. Patient Care Procedures (PCPs)
## PCPs, County Operating Procedures (COPs) and multi-county/inter-regional operations

### 1. System Status

**Process For Development And Review Of Regional PCPs & COPs**.

***Patient Care Procedures (PCPs) (Exhibit 2)***

Patient Care Procedures as defined in WAC are written operating guidelines adopted by the regional EMS/TC council, in consultation with local EMS/TC councils, emergency communications centers and the MPDs, in accordance with statewide minimum standards. The Patient Care Procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients are consistent with the transfer procedures in chapter 70.170 RCW.

In the East Region, the established policy falls under the authority of the Prehospital & Transportation Committee and allows for newly developed and/or revised Regional Patient Care Procedures to be mailed to all local EMS/TC councils, Medical Program Directors, and communications centers, as well as Regional Council members and alternates. Recommended changes are submitted to the Regional office, and the process begins all over again until the Regional Council adopts a Regional Patient Care Procedure. At that time, the document is forwarded to the DOH for review and approval.

***County Operating Procedures***

County Operating Procedures (COPs) are developed in much the same way as Regional Patient Care Procedures. They are developed at the county level and should include the same provider involvement as listed in WAC 246-976-960 (1) (g) as for regional Patient Care Procedure development. County EMS/TC councils, in conjunction with Medical Program Directors and communications centers, approve the procedure and forward it to the Regional Council, where the Prehospital & Transportation Committee reviews the document. If the Prehospital & Transportation Committee approves the document submitted, it is then sent forward to the Regional Council for adoption, or returned to the county council for further revisions. Once adopted by the Regional Council, the COPs are then forwarded to the Department of Health for review and approval. Once the Department has approved the document, it becomes an official part of that particular Regional PCP and is included in the Regional PCP Manual. All nine county EMS/TC councils have developed and implemented a COP for PCP #3, Triage and Transport.

The Regional Council has charged each of its nine county EMS/TC councils to develop, review, revise, and once adopted by the Regional Council, implement County Operating Procedures. These procedures outline how the county will implement regional Patient Care Procedures.

***Status Of Multi-County And Inter-Regional Protocols And Operations***

Medical Program Directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it be in another county, region or state. This ensures consistent patient care will be provided by personnel trained to use specific meds, equipment, procedures, and/or protocols until delivery at the receiving facility has been accomplished.

***Current Approved PCPs***

The following Regional PCPs have been developed, reviewed, updated and DOH approved.

| **Regional PCPs** | **Description** | **Approval Dates** |
|---|---|---|
| PCP #1 | Dispatch of Medical Personnel | 2/2005 |
| PCP #2 | Response Times | 10/28/2002 |
| PCP #3 | Triage & Transport | 10/28/2002 |
| PCP #3A | Triage & Transport of Pediatric Patients | 10/28/2002 |
| PCP #3B | Triage & Transport of Medical and Non-Trauma Patients | 10/28/2002 |
| PCP #4 | Interfacility Transfer | 2/2005 |
| PCP #5 | Medical Group Supervisor at the Scene | 2/2005 |
| PCP #6 | EMS/Medical Control Communications | 2/2005 |
| PCP #7 | Helicopter Response (1996 version is approved) | 2/2005 |

**2. System Need Statement**

The Prehospital and Transportation Committee spends a lot of time and energy in providing an annual review of Regional PCPs. Changes to Regional PCPs are made to reflect changes in the system and should be DOH approved and implemented regionwide in a timely manner.

County COPs are not being maintained and improved as often as necessary.

**3. Goal 1: Regional PCPs and COPs Within The Region Are Up To Date.**

**Objective 1:** ***Ensure that all County Operating Procedures available from county councils and relative to Regional PCPs are in accordance with and supplement the currently approved Regional PCPs by December 2006.***

**Strategy 2:** The Prehospital & Transportation Committee will monitor county COPs and make recommendations to county EMS/TC councils if updates are necessary annually by December in 2006.

**Objective 2:** ***PCPs will be implemented within 60 days after they are approved by DOH.***

**Strategy 1:** The Regional Council will work with the DOH through the RAC to update the approval process for PCPs as identified in the Regional Council Policy Handbook.

**Strategy 2:** Regional PCPs will be reviewed by the Prehospital & Transportation Committee annually.

**Projected Costs - Biennium**

| | |
|---|---|
| **Estimated System Costs** (County EMS/TC Councils & MPD Costs) | **$25,000** |
| **Regional Council Costs** (Travel, Committee and Staffing Costs) | **$ 5,000** |

**Barriers:** If the approval process is delayed implementation of revised PCPs is also delayed.

# V. Designated Trauma Care Services

## A. Trauma Services

### 1. System Status

***Table F. Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services (General Acute Trauma Services)***

| Level | State Approved | | Current Status |
|---|---|---|---|
| | Min | Max | |
| II | 1 | 2 | 2 (1 joint 1 single) |
| III | 3 | 4 | 3 |
| IV | 8 | 10 | 6 |
| V | 3 | 6 | 6 |
| II P | 1 | 2 | 1 |
| III P | 1 | 2 | 1 (Lewiston, Idaho) |

***Table G. Approved Minimum/Maximum (Min/Max) numbers of Designated Rehabilitation Trauma Care Services***

| Level | State Approved | | Current Status |
|---|---|---|---|
| | Min | Max | |
| I adult | 1 | 1 | 1 |
| II adult | 0 | 0 | 0 |
| III adult | 0 | 0 | 0 |
| I Pediatric | 1 | 1 | 1 |

The East Region's network of designated trauma services is an integral part of the EMS and Trauma Care System. There are nineteen designated trauma services within the East Region, including one joint designation. Fourteen of the designated trauma centers in the East Region are rural and have very different needs than the urban trauma centers. The highest level of trauma designation in the East Region is the joint level II adult designation of Deaconess (DMC) and Sacred Heart Medical Centers (SHMC) in Spokane and St. Joseph's Regional Medical Center in Lewiston, Idaho. There are three level III adult trauma designations in the region located in Spokane (2) and Pullman. The level IV and V trauma centers are located in the rural areas of the region. There is one level I adult and pediatric rehabilitation designated hospital in the region.

SHMCs Childrens Hospital is a designated level II pediatric facility with St. Joseph's Regional Medical Center in Lewiston providing the level III pediatric trauma designation.

A new development is the consolidation of previously shared level II Pediatric trauma services to SHMCs campus (Childrens Hospital), which will be the only East Region hospital providing level II pediatric trauma care. It will provide 24-hour Level II pediatric trauma care services. The one level I adult and pediatric trauma designated rehabilitation center in the region is not reapplying for the level I pediatric rehabilitation trauma designation. Outpatient Pediatric Rehabilitation at St Luke's Rehab is being evaluated for financial viability.

In 2005 the two largest hospitals in Spokane County, DMC and SHMC (Joint Level II adult and pediatric trauma designated facilities) combined, have laid off approximately 400 staff. Pediatric resources, including pediatric trauma resources were significantly impacted. A number of departments previously housed at DMC have been moved to the new Sacred Heart Childrens Hospital eliminating 56 pediatric personnel. This also resulted in the need for DMC to relinquish its Level II pediatric designation status. St. Luke's Rehabilitation Institute has also experienced a reduction in pediatric patients as a direct result of the layoffs and reorganization of SHMC and DMC and is not reapplying for a level I pediatric rehabilitation trauma designation. The lack of reimbursement through the Enhanced Trauma Reimbursement program in the last biennium and the changes to the Washington State Indigent Program has an ongoing devastating effect on trauma facilities in this region.

An unstable workforce situation exists that could impact trauma care particularly in rural communities. Many rural facilities have more part-time employees than they do full-time employees. Medical personnel living in these communities used to be able to find part-time or on-call work in other hospitals within the region. Today, they are traveling to Idaho or neighboring regions to find work.

The Regional Council provides recommendations for minimum and maximum numbers, levels and locations of trauma designations annually to the DOH based on recommendations from the hospitals themselves. Recommendations are based on the needs and capabilities of a hospital's particular community. Although there are changes in the pediatric level of designation by two specific facilities, the Regional Council does not have enough information at this time to recommend changes to the minimum/maximum numbers of trauma designated facilities currently approved by the DOH. However, the changing health care system in the East Region may result in recommendations during the biennium. As Deaconess Medical Center relinquishes its Level II trauma designation a change in level II or III min/max numbers may be needed to include Deaconess as a designated pediatric service at some level. The same may apply for St. Luke's Rehabilitation Institute.

**Network of Designated Trauma Care Services**

***Current Trauma Designated Services***

| | | |
|---|---|---|
| Spokane Joint Trauma Services | Spokane | Level II adult |
| (Deaconess Medical Center & Sacred Heart Medical Center) | | |
| Sacred Heart Medical Center | | Level II Pediatric |
| St Joseph's Regional Medical Center | Lewiston, Idaho | Level II adult & III-Pediatric |
| Holy Family Hospital | Spokane | Level III adult |
| Pullman Regional Hospital | Pullman | Level III adult |
| Valley Hospital & Medical Center | Spokane | Level III adult |
| Deer Park Health Center & Hospital | Deer Park | Level IV adult |
| Lincoln Hospital | Davenport | Level IV adult |
| Mount Carmel Hospital | Colville | Level IV adult |
| Newport Community Hospital | Newport | Level IV adult |
| St Joseph's Hospital of Chewelah | Chewelah | Level IV adult |
| Tri-State Memorial Hospital | Clarkston | Level IV adult |

| | | |
|---|---|---|
| East Adams Rural Hospital | Ritzville | Level V adult |
| Ferry County Memorial Hospital | Republic | Level V adult |
| Garfield County Hospital District | Pomeroy | Level V adult |
| Odessa Memorial Hospital | Odessa | Level V adult |
| Othello Community Hospital | Othello | Level V adult |
| Whitman Hospital and Medical Ctr. | Colfax | Level V adult |
| | | |
| St Luke's Rehabilitation Institute | Spokane | Level I adult/pediatric |

***Critical Access Hospitals***

The Critical Access Hospital program is a major influence in the East Region EMS and trauma system. All thirteen (14 including Dayton General Hospital in Columbia County) rural trauma designated facilities in the region are Critical Access Hospitals. This represents almost 40% of the 37 hospitals in Washington with this designation. Currently in Washington State all Critical Access Hospitals must be designated trauma services. The federal Critical Access Hospital (CAH) Program was created by the 1997 federal Balanced Budget Act as a safety net device, to assure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options relative to community need, simplify billing methods and create incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care. In Washington State, the Critical Access Hospital program is administered by the Department of Health through the Office of Community and Rural Health (OCRH) and the Office of Facility and Services Licensing (FSL) Office of Survey, in close collaboration with the Washington State Hospital Association.

| **Current Critical Access Designated Hospitals** | **Start Dates** |
|---|---|
| Garfield Co. Memorial | August 1999 |
| Lincoln Hospital | August 2000 |
| Deer Park Hospital | November 2000 |
| Odessa Memorial Hospital | January 2001 |
| St. Joseph's Hospital in Chewelah | August 2001 |
| Newport Community Hospital | October 2001 |
| East Adams Hospital | January 2002 |
| Othello Community Hospital | July 2002 |
| Ferry County Memorial Hospital | January 2003 |
| Mount Carmel Hospital | June 2003 |
| Whitman Hospital | August 2003 |
| Pullman Regional Hospital | June 2004 |
| Tri-State Memorial Hospital | August 2004 |
| (Dayton General Hospital) | (January 2000) |

***Other System Status Information***

Rehabilitation is visibly a critical system component of the East Region EMS & Trauma Care System. The Director of Rehabilitation Services at St. Luke's Rehabilitation Institute chairs the East Region Rehab Committee, serves on the Regional Council and is a member of the Executive Board. St. Luke's has rehabilitation representation on the regional Quality Improvement Committee, as well as representatives who served on the Hospital Planning Committee. A rehab presentation is provided to the Regional Council annually. Within the biennium, a patient case review is coordinated with the Quality Improvement Committee. The case review is then presented to the Regional Council and to the Steering Committee. There is discussion about the patient case review being presented at the East Region EMS Conference in March of 2006.

**2. System Need Statement**:

***Gaps in the Current System***

A primary system need for trauma services in the East Region is resource stability. There are a number of emerging system issues that either currently or potentially may impact the resource stability and trauma care. How the reorganization of the two large hospitals in the region, including consolidation of pediatrics decrease of 400 staff, will affect the EMS and trauma system and patient care has not yet been determined. Medical doctors and other medical professionals are not readily available in rural areas of the region. Nurses and other staff may only work part time at their community hospital and may seek additional work hours outside of their county/region. The number of Critical Access hospitals in this region highlights a need for hospital financial stability that is currently not available in this region. Many rural areas have difficulty getting physicians and/or physicians' assistants to live in their communities. Many areas, if they are lucky, are able to share coverage by physicians in neighboring counties. If it were not for grant funding through the Critical Access Hospital program and other rural health programs, many of these facilities would have to close their doors. This would impact rapid accessibility to trauma care within rural communities.

There are some medical clinics in the East Region that do not have critical access hospitals. Transports are commonly required from clinics and Critical Access Hospitals to urban area facilities for the continuum of patient care.

**3. Goals**

**Goal 1: Designated Trauma Service resources are maintained at the level necessary to meet trauma patient care needs**.

**Objective 1:** ***Hospital and medical staff leaders from the trauma services will meet by January 2006 to discuss the current health care delivery issues related to trauma care and determine what resources are needed for a stable regional trauma system.***

**Strategy 1:** The regional council, through its Hospital Planning Committee will assist in meeting set up as requested**.**

**Strategy 2:** A statement on needed resources (possibly a white paper/position paper) will be developed and utilized to support the system as determined by the hospital community.

**Goal 2: Rehabilitation Education and Resource Training is Available Regionwide.**

**Objective 1:** ***All Rehabilitation Centers in the East Region are aware of current education and patient care resources by June /2007.***

**Strategy 1:** The Rehab Committee will work with its membership to develop and host a Rehabilitation Conference by 6/2007.

**Strategy 2**: The Rehab Committee will review spinal cord trauma in patients over the prior 2 years and submit an appropriate case to the QI Committee by 10/31/05.

**Strategy 3**: The Rehab Committee will complete the case review on the chosen trauma patient by 6/30/06.

**Strategy 4**: The Rehabilitation Committee will design a webpage by 8/31/05 that will be added to the EREMSTCC website. The website will be updated quarterly or as needed.

**Strategy 5:** The Regional Rehab Directory will be updated, distributed to Regional Council members, and made available on the website by 6/2007.

**Projected Costs - Biennium**

**Estimated Systems Costs (Too enormous to calculate)**

**Regional Costs** **$1,500**
(Travel Expenses for Committee & Council Members)

**Barriers:** The Regional Council has no authority over hospitals. Many of the needs identified in this section are a direct result of today's economy. The Regional Council offers itself as a way for facilities to discuss issues related to health care as it affects the EMS & Trauma system. The Council will provide this service only upon request.

# VI. EMS and Trauma System Evaluation

## A. Information Management (Washington State DOH Approved Plan Modifications - 2/6/2006)

### 1. System Status:

***Regional Involvement In Statewide Planning For The Washington EMS Information System (WEMSIS)***

The Regional Council has representation on the DOH EMS Registry TAC who reports at council meetings on the progress of the planning process. The Regional Council participates in DOH requested surveys and other projects as is appropriate.

***EMS Data Collection By Prehospital Agencies Within The Region***

Transport agencies are leaving paper medical incident reports at the receiving hospital 92.5% of the time. Some agencies use NFIRS to collect data and others still use *Collector*. Other non-transporting agencies may or may not be collecting data electronically. In some cases, first response data may be offered to the transporting unit, but may not be accepted.

***Availability Of EMS Run Times From Dispatch Centers***

A recent survey of 9-1-1 Centers in the region indicate that dispatch centers provide run times to EMS providers on a regular basis. Some EMS agencies request this information after each run, some weekly and some monthly.

***Submission Of Timely Prehospital Trauma Data To Receiving Trauma Services***

DOH 2004 data states that approximately 92.5% of all prehospital run reports are being left at the receiving hospital. Although hospitals do not generally receive run reports from the first response agency, they do agree that the information is important to patient care.

### 2. System Need Statement:

In order to provide quality patient care there needs to be a system by which all prehospital agencies, both transport and non-transport can submit trauma and medical data to the state registry..

## 3. Goals

**Goal 1: Regional Council is informed About Data Collection Regionwide**

**Objective: Data Collection Information is Available from All Prehospital Transport Agencies by 6/2007.**

**Strategy 1:** Working with the DOH, the Regional Council will host a Washington Emergency Medical Services Information System (WEMSIS) Workshop in the fall of 2005.

**Strategy 2:** Enlist at least one prehospital agency to participate in the WEMSIS pilot project, if applicable.

**Projected Costs - Biennium:**

**Estimated System Costs - Unknown**

**Regional Council Costs $ 5,000**

**Barriers:** It is believed data submission will be done voluntarily by prehospital agencies. It may be difficult to determine the cost of submitting data Regionwide.

## VI. EMS and Trauma System Evaluation

## B. Quality Assurance (Washington State DOH Approved Plan Modifications - 2/6/2006)

### 1. System Status

Quality Improvement is critical to the evaluation of the EMS & Trauma System in the East Region. A broad look at what contributes to community health must include data from hospitals and prehospital agencies, so comprehensive care at the right time and at the right place can be ensured in each community. Accurate regional data can provide specific information about the health of our EMS & Trauma System and individual communities, facilities, and about prehospital services.

The QI Committee is not affiliated with the Regional Council; however this section of the plan was written and approved by the QI Committee. It is the desire of the Regional Council to include QI reporting at each Regional Council meeting as well as in the monthly report. In the past the Council encouraged the QI Committee Chair to participate with the Regional Council's Chairs and Executive Committee. In FY 05 the QI Committee provided reports to the Regional Council on the progress of each goal, objective and strategy identified in that plan.

The QI Committee does not review and/or approve any policy or procedures developed by the Regional Council including but not limited to PCPs. The Quality Improvement section of each PCP states the following:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

***Prehospital agency level QA functions within the regional system for patient care evaluation of general EMS patients and for Trauma patients***

Individual prehospital EMS agencies develop and conduct their own internal QA processes for EMS patients.. Agencies are not required to follow a particular method or model in developing their internal agency QI process. Run review is a common model used. County MPDs provide additional review of runs and provider practice.

DOH provides the Regional QIC with both hospital and limited prehospital trauma data which allows for QI of trauma cases including limited prehospital agency level care review. The committee periodically reviews the prehospital response times with response times for trauma patients identified in the Regional Patient Care Procedure. Presentations on the findings are distributed to facilities, local councils and to the Regional Council. This is the type of information that would affect system changes. The Regional Council has tasked the Prehospital & Transportation Committee to also review the data for compliance with PCPs.

***Current role of the MPD in prehospital QA/QI***

RCW and WAC provide authority for MPD role in providing oversight of the prehospital care at the county level. There is no MPD involvement at the Regional level for QI, however

MPDs are very active at the local level carrying out their medical oversight rolls. MPDs are responsible for developing their own processes for QA on EMS runs and EMS provider practice. There is not currently a regional QA process that addresses general EMS patients. System-wide general EMS data is not available for use looking at the regional system. MPDs work with members of the local council to provide oversight of QI for prehospital agencies.

***Function of the Regional EMS and Trauma QA Program within the regional system for trauma care evaluation***

The regional Quality Improvement Committee (QIC) provides oversight of the regional EMS and Trauma System by evaluating hospital and limited prehospital trauma data. Trauma patient data is provided to them by the DOH. The QIC operates as a hospital developed and run program and uses a case review model. It provides periodic aggregate reports to the Regional Council on system level information.

The QIC meets periodically and is primarily attended by hospital level members. The regional Quality Improvement Committee is represented by each of the nineteen trauma designated facilities, prehospital providers, Injury Prevention, Public Health, rehabilitation, air ambulance and Regional Council. When the committee was first developed years ago, physician participation was good. Today, physicians do not participate at the regional level. Medical Program Directors are actively involved at the local level. MPDs are not active in the Regional CQI meetings.

***The use of QA/QI Data For Developing Recommendations For Change System***

Data provided by the DOH is reviewed by the QIC. The QIC may then provide a presentation of the data and its findings to the Regional Council. If the data implies that a change in the system may be necessary, the Council assigns review of the data to the specific EMS committee that provides oversight for that activity. The EMS committee may then provide a recommendation back to the Regional Council that would affect a system change.

**2. System Need Statement**

***Identified Needs Within The Region***

Until recently nurses have provided leadership for the QIC in this region. There is a need for the leadership to be provided by a medical doctor. There is a need for the QIC to create more vital connections between the entities that are involved in trauma patient care so that the quality improvement process will result in all of the right people looking at the system of care and making appropriate changes that are focused on patient care.

- Leadership of the QIC needs to be a physician.
- MPDs and physicians need to be involved in the QIC to ensure system changes to the EMS and Trauma System are data driven.

***Issues That Limit Effectiveness of QA in the East Region***

Total data, including pediatric data, is needed for system evaluation. Lack of physicians and MPD membership to provide leadership drastically limits the effectiveness of the QIC.

## 3. Goals

**Goal 1: System Data Is Available to the Regional Council**

**Objective 1:** *The Regional Council will use available system data for review and planning efforts in the biennium.*

**Strategy 1:** Contact the DOH for data as needed for system planning and review.

**Strategy 2:** Use the available appropriate data for planning the next plan.

**Projected Costs - Biennium**

| | |
|---|---|
| **Estimated System Costs (Approximate for QIC)** |  **0,000** |
| **Regional Council Costs** | **$0** |

# VII. All Hazards Preparedness

**(natural, man made, & terrorism/WMD)**

## A. Prehospital Preparedness

### 1. System Status

The Regional Council has contracted with the DOH, Bioterrorism Preparedness Team to facilitate and coordinate prehospital and hospital all hazards planning. The Prehospital & Transportation and Training & Education Committees have authority over this planning process.

***Level Of Collaboration Across Disciplines Within The Region For All Hazards Preparedness Planning And Exercises/Drills***

To date the region (ten counties) has only participated in one table top exercise which was available via video conferencing with 11 sites online. The drill involved nearly all disciplines including EMS. It was difficult for EMS providers to participate in the table top simply because many of them were needed to cover their response areas.

***Regional Council's role in prehospital All Hazards planning and activities within the Region***

To date there has not been a lot of all hazards planning for prehospital providers. The Regional Council will participate, through the RAC, in the development of a state Trauma and Burn Capacity PCP. Other deliverables, including forward movement of patients will be accomplished through the Prehospital & Transportation Committee.

**Status of WMD preparedness**

***Prehospital WMD Equipment***

Some prehospital providers in various counties have received PPE and/or decontamination equipment through their county Emergency Management Department. The Regional Council does not have a complied list that identifies the kinds of equipment prehospital agencies have what they do not.

The HAZMAT team out of Spokane County would respond to biological and/or chemical incidents. Whitman County has a HAZMAT team (unofficial) that also responds to these kinds of incidents.

***Prehospital WMD Awareness Training***

A number of years ago the Regional Council provided WMD Awareness and Technician training to EMS providers regionwide. Approximately 250 providers were trained at that time.

**Written Agreements Between Prehospital Agencies For Mutual Agency Response In Disaster For WMD Natural/Manmade Incidents**

Most counties have General EMS Mutual Aid Agreements that are in place within and outside of normal response areas. Those documents have been in place for EMS since 1996.

MAA, specifically for all hazards events are few and far between. The Regional Council allows the Fire Chiefs Association(s) to oversee those kinds of documents.

**Current Interoperability Between Agencies And Across Multiple Disciplines In Multiple-Patient And Mass Casualty/Disaster Incidents For:**

***Equipment Resources (Compatible Care Equipment, Radios Etc)***

Equipment sharing in Spokane County is done throughout the county and includes units, resources, equipment and personnel. Interoperability between agencies in the other eight counties is identified in Mutual Aid Agreements and also covers units, resources, equipment and personnel. There is no formal written plan that provides interoperability between agencies and across multiple disciplines.

***EMS Agencies Communications (With Dispatch, Between Units And Disciplines***

EMS agencies have the ability to talk with 911 Centers by telephone. VoIP (Voice over Internet Protocol) is also available; however some 911 centers do not have VoIP on a 911 line.

Spokane County has provided WSP the capability of speaking with the 911Center from the field. Whitman County is in the process of implementing this capability. Other 911 centers are slow to implement this process or are just not capable of doing so.

EMS agencies communicate to hospitals via the HEAR Radio or by telephone.

***Across The Region, And With Receiving Hospitals For On-Line Medical Direction***

HEAR Radio is used for prehospital to hospital communications in this region. Prehospital providers contact medical control, generally at the hospital Emergency Room, for on-line medical control.

***WMD Patient Care Procedures/Protocols/Guidelines***

There are currently no Regional WMD PCPs. Some county EMS/TC councils, in collaboration with their MPDs, have developed protocols and /or guidelines for WMD incidents. Spokane County has been active in this area.

## 2. System Need Statement:

### Existing Needs Within The Region Related To All Hazards Preparedness:

***Communications***

The Communications Committee is working to develop a needed Communications proposal for hospital to hospital communications. Once that proposal has been developed, it will be expanded to address the need to include prehospital to hospital communications. The FCC has announced that HEAR Radio will be moving to narrow band by 2007, so a new communications system may be necessary. Funding to support this project is not available through Regional Council funds.

- ***WMD Awareness Training***

At a minimum the WMD 160 Awareness class is necessary for prehospital providers. Approximately 250 providers have been trained; however there are still 2,000+ providers that still need training. The Regional Council does not currently have funding to provide this kind of training. Individual agencies are responsible for getting and paying for WMD training through other sources like WMD funding. The Regional Council plans to address developing a strategy to determine training needs during the biennium.

- ***WMD Equipment***

There is equipment available to meet the needs of the agency, hospital and other facility needs to meet the need of a WMD event. This equipment is not limited to Personal Protective Equipment (PPE), hospital and prehospital HAZMAT, assessment equipment, mass casualty equipment such as bandages, oxygen, triage tags, stretchers, backboards, etc. The Washington State approved ODP list of equipment is 37 pages long. Equipment from this list can be purchased with WMD funding. The Regional Council does not know which pieces of equipment are still needed by individual agencies but plans to address this through a survey process during the biennium.

- ***Written All Hazards Mutual Response Agreements***

The Regional Council developed a general Mutual Aid Agreement years ago that all agencies in the region have signed. These agreements are in place for an EMS and/or trauma event. Specific *all hazards* mutual response agreements are not available to EMS providers at this time. The DOH is collaborating with the State Regional Advisory Committee, in which the East Region participates, on doing some work in this area.

- ***Preparedness Exercises Of Various Types For Natural, Manmade, And WMD Incidents***

There is a need for the Regional Council to be more aware of the drills, exercises and/or Table Tops that EMS agencies throughout the region are participating in.

- ***Interoperability Between Agencies And Across Multiple Disciplines***

Interoperability between agencies is in its early stages. Currently many of the 911 centers are providing WSP with the capability to link to their centers. There is a need to determine what interoperability is in place and what needs to be put in place. The Communications Committee, to the extent possible, will determine what interoperability is in place during the biennium.

***Prehospital Field Care, Equipment, And Transport For 50 Burn Patients Per Million Population Per Day***

The Regional Council, through the RAC, needs to develop a PCP to cover Trauma and Burn Care for 50 burn patients per million population per day. That activity has not yet begun but should be at least in a draft stage by August 2005.

**3. Goals**

**Goal 1: Identify Prehospital WMD Needs By June 2007.**

**Objective 1:** ***Prehospital providers are prepared to respond to all hazards incidents by June 2007.***

**Strategy 1:** Working with various disaster planning groups, including Homeland Security and the county EMS/TC councils, the Training & Education Committee will develop a survey to identify the types of WMD training prehospital providers in the East Region still need by June 2006.

**Strategy 2**: The Prehospital & Transportation Committee will work with existing planning groups and county EMS/TC councils to develop a survey for distribution to prehospital providers regionwide to identify the types of equipment that can be used in a WMD event by June 2006.

**Strategy 3**: In collaboration with the DOH, RAC and the Prehospital & Transportation Committee determine the role of the Regional Council in the development of All Hazards Mutual Aid Agreements by June 2006.

**Strategy 4**: Develop a method to identify interoperability between disciplines by June 2007.

**Strategy 5**: Working within the RAC and DOH, develop a broad based Patient Care Procedures for burn care for 50 patients that can be adopted at the regional level by June 2006.

**Projected Costs - Biennium**

| | |
|---|---|
| **Estimated System Costs** | **Unable to Calculate** |
| **Regional Council Costs**<br>Travel and Administration | **$2500** |

**Barriers:** Direction from the DOH and other lead agencies is imperative if all hazards planning is going to be successful. Funding for training, equipment and drills is not available through the Regional Council.

## VII. All Hazards Preparedness

### B. Hospital Preparedness

### 1. System Status

Public Health Emergency Preparedness Response (PHEPR) Region 9 consists of all nine counties in the East Region as well as Columbia County, making it the largest geographical region (10 counties) in the State of Washington. There are 22 hospitals in the region.

Funding is available through the HRSA grant to the Washington State DOH, Bioterrorism Preparedness Team and is allocated according to an identified formula to each of the nine regions in the state. Eastern State Hospital (ESH), Veterans Administration (VA) and Shriners Childrens Hospital (SCH) do not qualify for funding under the HRSA grant. ESH is a state hospital; VA is a federal hospital; and Shriners is funded through a foundation. All of the EMS & trauma designated hospitals (identified in section V) are actively involved in the all hazards planning process.

The co-chairs of the East Region's Hospital Planning Committee (HPC) represent public health and hospitals. The Hospital Planning Committee falls under the authority of the Regional Council and is identified in the bylaws as an active working committee with specific responsibilities.

Administration of the committee activities is coordinated through the Regional Council with collaboration from public health, Homeland Security and the DOH, all of whom participate in the planning process by attending HPC meetings. The Regional Emergency Preparedness Coordinator (RERC) has been very supportive of hospital activities requiring facilitation and/or coordination by Regional Council staff. The partnership between the Regional Council and public health is strong.

### Other Systems Information

***Communications***

Urban and rural hospitals do not have the capability of communicating to each other unless it is done via telephone, Internet or through ARES/RACES. The DOH will be installing ARES/RACES radio equipment and antennas as well as stationary satellite phones and antennas in each of the hospitals by August 31, 2005.

Currently the Communications Committee (consisting of a number of community partners) is working in collaboration with the HPC to identify a plan the installation of a hospital to hospital communications system. Hospitals in Spokane County can speak to each other sometimes over the HEAR Radio hospital frequency. It has recently been identified that most facilities do not have access to the frequency identified specifically for hospital use. The HEAR Radio will require an additional receiver to be placed in each of the facilities for there to be hospital to hospital communications. The Communications Committee will be researching and providing recommendation to the HPC on whether to update the old equipment or purchase new equipment. It is anticipated that funding would come from the HRSA grant.

***Bed Capacity***

Spokane County EMS and Inland Northwest Health Services have developed RAMSES which is an online program available to hospitals, public health, Homeland Security, Emergency Management, EMS and other entities involved in all hazards preparedness. The program the various disciplines to put messages on the board that might indicate the level of threat, a specific illness that public health may want to make people aware of, or in the instances of hospitals, to identify department bed availability.

Currently all of the hospitals in Region 9 are online with RAMSES and manually update available bed capacity daily. The HPC has recently voted unanimously to adopt RAMSES as the program to identify facility bed capacity. There is a contract between the DOH and Inland Northwest Health Services (details still being worked out) to update RAMSES so that it will automatically update bed capacity every 24 hours through Medetech, which is the patient software being used by all hospitals in the region except East Adams Rural Hospital.

***Level Of Collaboration Across Disciplines Within The Region For Hospital Disaster Readiness Planning, Exercises/Drills***

Although neither the Regional Council nor the Hospital Planning Committee is actively involved in the planning of exercises/drills, participation and participant collaboration is high. The first regionwide table top exercise was held in May of 2004 via video conferencing. Thirteen sites participated in the drill that included all ten counties, Idaho and two observation sites. This was the first drill nationwide to be conducted in this manner. It was a huge success! Hospital planning committee members are on exercise planning committees with public health at the local and regional level, including Caduceus, Caduceus II and local LHJ tabletops.

Contract language during FY 04 and 05 has identified the need for at least one table top exercise/drill per year. It is anticipated that this requirement will continue through 2007. Most facilities participated in two drills during FY 05; one drill was forward movement of patients and the other was a table top with public health participation involving one biological agent and special populations. Joint Commission on Accreditation of Healthcare Organizations (JACHO) requires facilities to participate in at least one mass casualty drill per year.

Disciplines participating in the drills include but are not limited to: EMS, fire, law, public health, hospitals, Emergency Management, Homeland Security, state and federal organizations, Fairchild AFB and ARES/RACES.

***Regional Council's Role in Hospital All Hazards Planning and Activities***

The hospital committee is a standing committee under EREMSTC. Public Health is the lead agency for HRSA and CDC grant activities with hospitals. Public Health and EMS work collaboratively through the hospital committee for facilitation, coordination and completion of contract deliverables.

***Regional Hospital Plan - Preparedness and Response for Bioterrorism***

The HPC voted to contract with Inland Northwest Health Service in FY 03 to develop the first Regional Hospital Plan for disaster response. The plan was updated in FY 04 and submitted to the DOH on August 31 2004. It is a contract deliverable in this year's contract to update and submit the plan to the DOH by August 31, 2005. It is anticipated that this will be an annual requirement.

It is the intent of the HPC to update sections of the plan annually as it relates to benchmark completion. Committee members have formed subcommittees to work with staff on updating the plan.

***Completion of Hospital WMD Awareness Training***

Early on the Regional Council realized that it was going to be necessary to provide WMD training for hospital and prehospital providers alike. Approximately five years ago the Regional Council contracted with the Inland Empire Training Council to provide 8 awareness and 4 technician courses in the rural area of the region to providers. The courses were authorized by the ODP and funded by Homeland Security. Spokane County participated in WMD training and later Sacred Heart Medical Center offered WMD to regional providers.

***Hospital WMD Readiness Equipment (PPE, Decontamination, Etc)***

PPE and decontamination equipment is being provided to hospitals through Homeland Security and DOH in 4 phases. Phases are identified in the table below along with the receiving facility.

**PHASED EQUIPMENT ALLOCATIONS**

(NOTE: Some hospitals have additional beds in long-term care/assisted living facilities on their campuses. Those numbers are not included here.)

**Phase I (2002 Sept 2002 – Aug 2003)**

| Hospital | City | County | Region | Beds |
|---|---|---|---|---|
| Deaconess Medical Center | Spokane | Spokane | 9 | 388 |
| Mount Carmel Hospital | Colville | Stevens | 9 | 33 |
| Sacred Heart Medical Center | Spokane | Spokane | 9 | 535 |
| Whitman Hospital & Med Center | Colfax | Whitman | 9 | 48 |

**Phase II (2003 Sept 2003 – Aug 2004)**

| Hospital | City | County | Region | Beds |
|---|---|---|---|---|
| Dayton General Hospital | Dayton | Columbia | 9 | 15 |
| Holy Family Hospital | Spokane | Spokane | 9 | 272 |

**Phase III - DRAFT (2004 Sept 2004 – Aug 2005))**

| Hospital | City | County | Region | Beds |
|---|---|---|---|---|
| East Adams Rural Hospital | Ritzville | Adams | 9 | 20 |
| Ferry County Memorial Hospital | Republic | Ferry | 9 | 11 |
| Garfield Co. Public Hospital District | Pomeroy | Garfield | 9 | 25 |
| Newport Community Hospital | Newport | Pend Oreille | 9 | 24 |
| Odessa Memorial Healthcare Center | Odessa | Lincoln | 9 | 44 |
| Pullman Memorial Hospital | Pullman | Whitman | 9 | 42 |
| St. Joseph's Hospital | Chewelah | Stevens | 9 | 25 |

**Phase IV – DRAFT (2005 Sept 2005 – Aug 2006)**

| Hospital | City | County | Region | Beds |
|---|---|---|---|---|
| Deer Park Hospital | Deer Park | Spokane | 9 | 25 |
| Lincoln Hospital | Davenport | Lincoln | 9 | 24 |
| Othello Community Hospital | Othello | Adams | 9 | 49 |
| St. Luke's Rehabilitation Institute | Spokane | Spokane | 9 | 102 |
| Tri-State Memorial Hospital | Clarkston | Asotin | 9 | 62 |
| Valley Hospital & Medical Center | Spokane | Spokane | 9 | 123 |

**2. System Need Statement:**

***The Development and Implementation of the Regional Hospital Plan - Preparedness and Response for Bioterrorism***

The hospital plan is required to be updated and submitted to the DOH by August 31, 2005. It is the intent of the HPC to update the plan as benchmarks/contract deliverables or other projects are completed.

***Awareness Level Training Of Hospital Personnel***

All disciplines involved in all hazards events still need training. Currently Awareness 160 is the course recommended by the ODP for all disciplines. Online training is being developed by the Washington State Department of Health. FEMA also offers online training. Reimbursement for WMD training is available through the HRSA grant if identified in the annual hospitals need prioritization list and approved by the DOH. Washington Public Health Training Network (WPHTN) is the data base being developed at the state level and will be administered by the Regional Learning Specialist (RLS) within the region. It has not been determined at this writing how broad the database will be, but it is expected to be able to identify all WMD training regionwide.

***Equipment (PPE, Decontamination, Etc,)***

The table in the System Status of this section identifies when PPE and decontamination equipment will be delivered. Training is provided to hospitals on the PPE and equipment either before or after delivery. No other needs have been identified at this time. No further action is required of the HPC or the Regional Council.

***Drills/Exercises***

Homeland Security has expressed the need for hospital and public health requirements to fall under the authority of the ODP. When that happens, requirements can be combined and coordinated so benchmarks and deliverables can be combined and completed in one drill.

In FY 05 many disciplines had the opportunity to participate in an NDMS drill. The drill was organized by public health as a mass forward movement of patients exercise and was to include various disciplines. Some disciplines pulled out of the planning process a few months prior to the drill date which then changed the focus and outcome of the drill.

***Burn Care for 50 Patients per Million Populations per Day***

The DOH is working with the Washington State Hospital Association to develop a survey that will identify hospital capability and needs to meet the goal of providing trauma and burn care to at least 50 severely injured adult and pediatric patients per million of population. This committee is also working to develop language for inclusion in the regional Hospital Bioterrorism Plan. The procedure developed by Harborview has been shared with regional facilities.

**3. Goals**:

**Goal: Hospital All Hazards Preparedness Meets Requirements Of The HRSA Benchmarks by June 2007.**

**Objective:** ***Hospital all hazards preparedness will be accomplished through collaboration between EMS, Public Health and regional hospitals by the completion of DOH contract deliverables identified in the organizations' annual contract with the DOH.***

**Strategy 1:** Contract deliverables will be completed as identified in the *annual* contract between the Regional Council and the DOH by August 31st of each year.

**Strategy 2**: Contract deliverables and benchmarks will be completed by hospitals as identified in the *annual* contract between individual hospitals and the DOH by August 31st of each year.

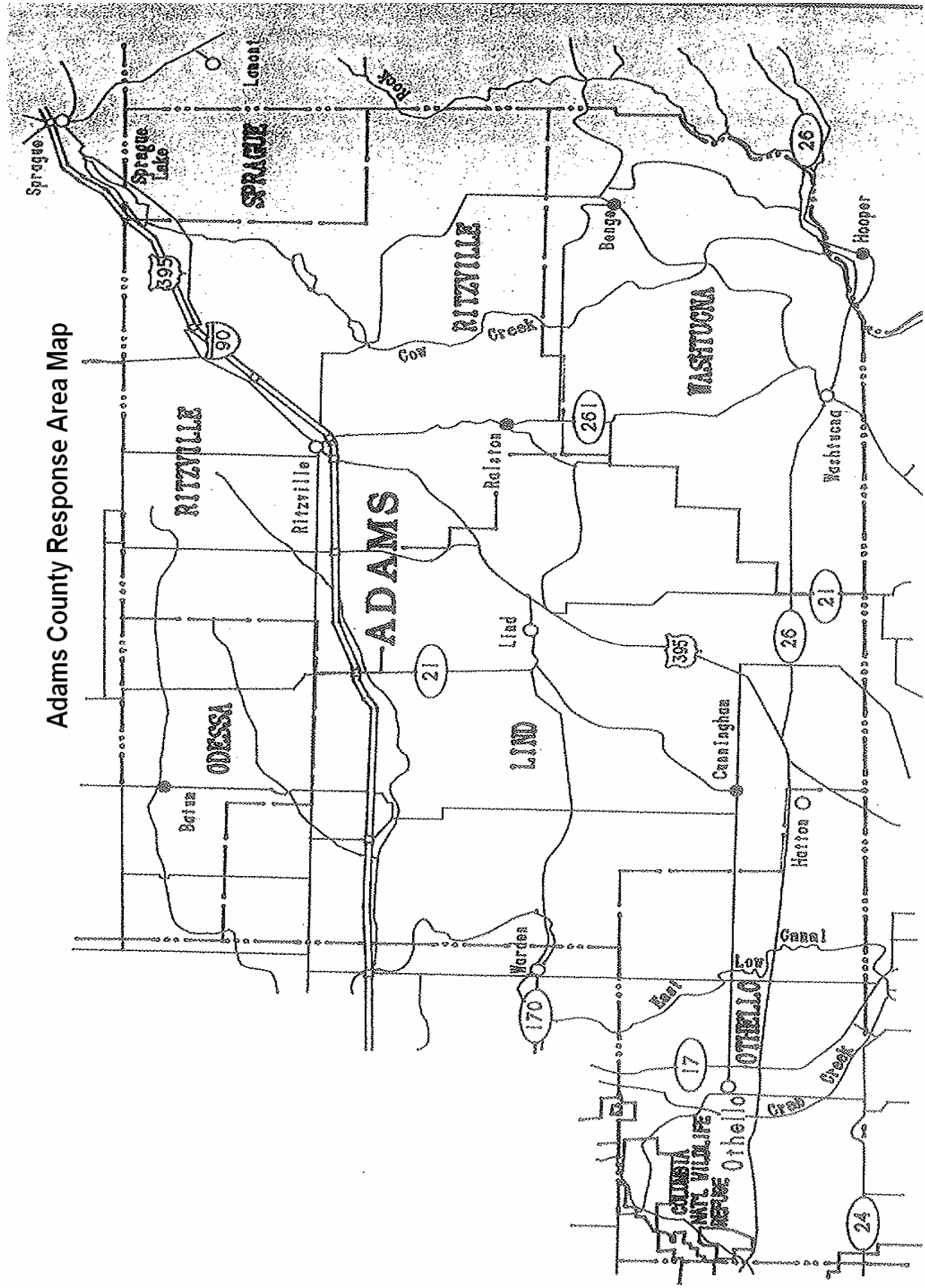
**Projected Costs - Biennium**

| | |
|---|---|
| **Estimated System Cost** | **$3,500,000** |
| **Regional Council Costs** | **$ 150,000** |

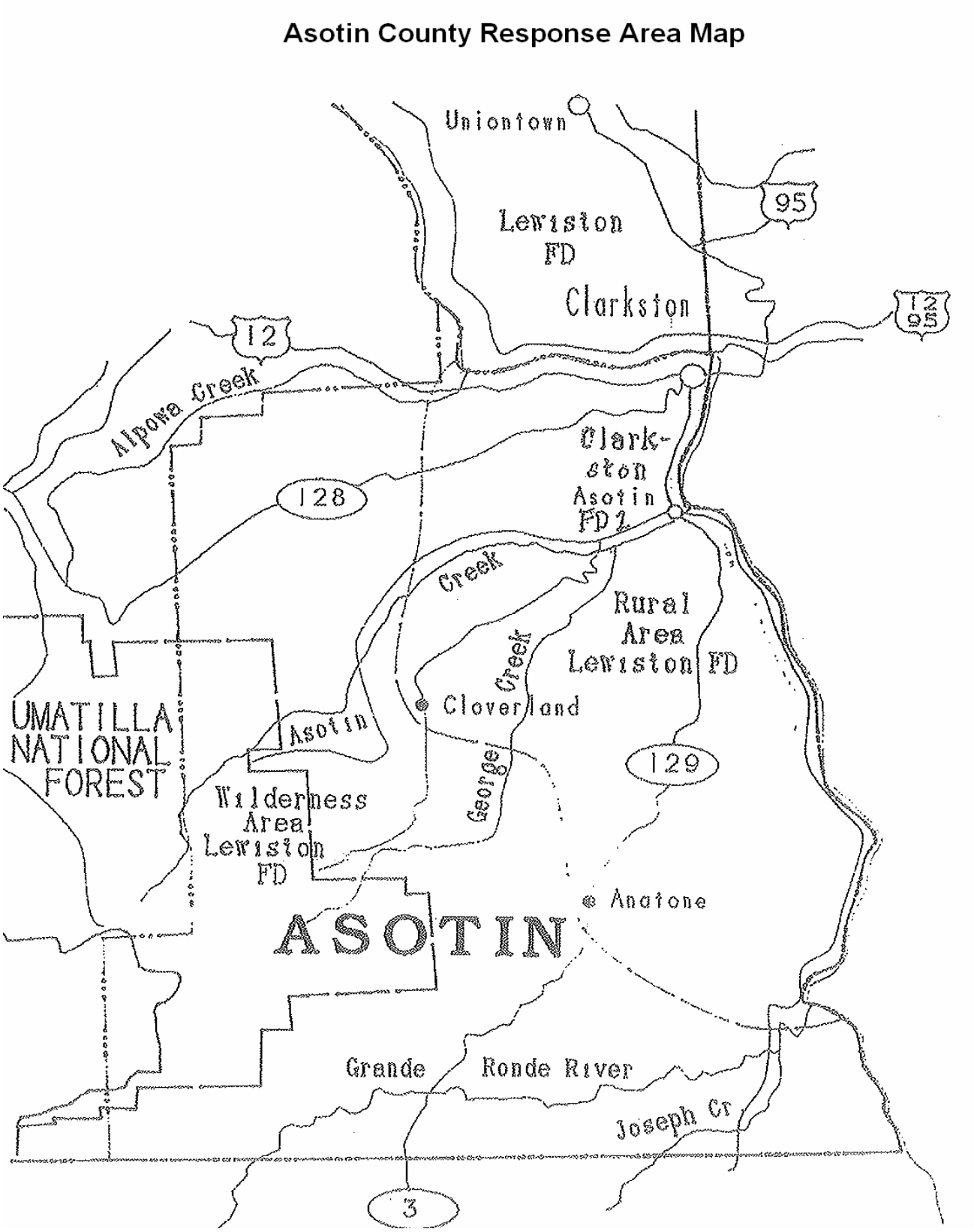
**Barriers:** All hospitals must participate in benchmarks, contract deliverables and/or drills in order for the region to be successful in all hazards preparedness.

# Exhibit I – East Region Trauma Response Area Maps

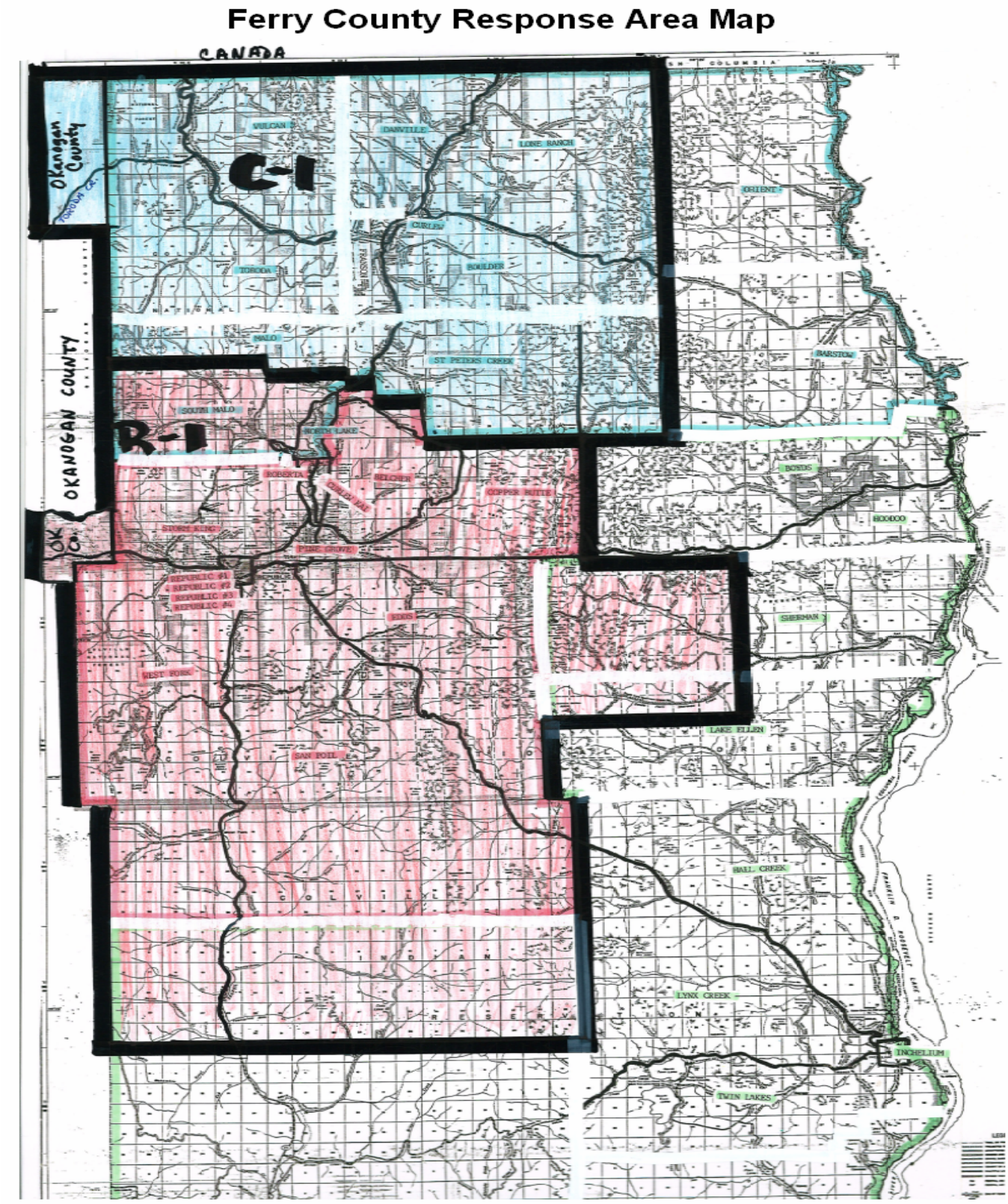
## Adams County Trauma Response Area Map



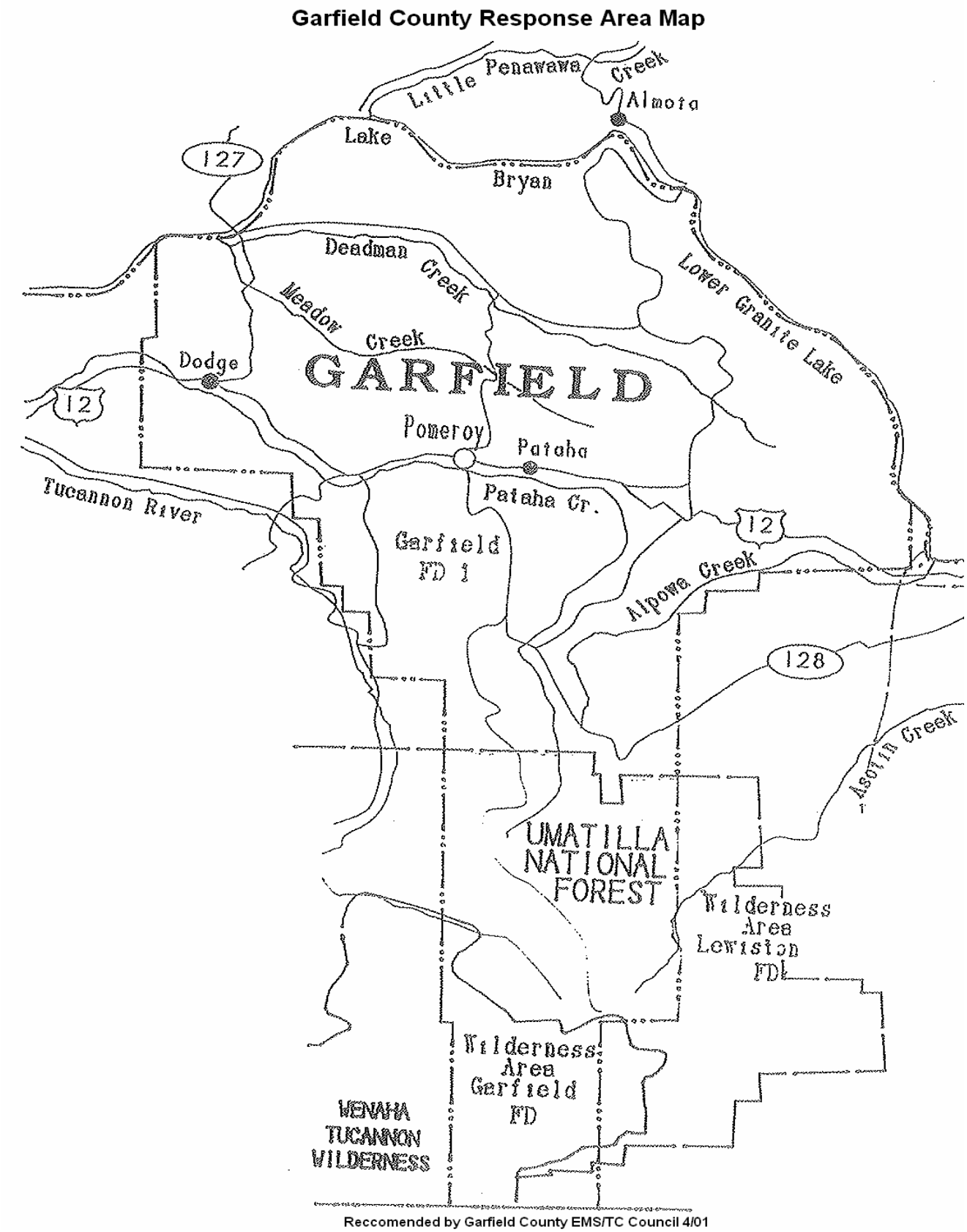
**Asotin County Trauma Response Area Map**



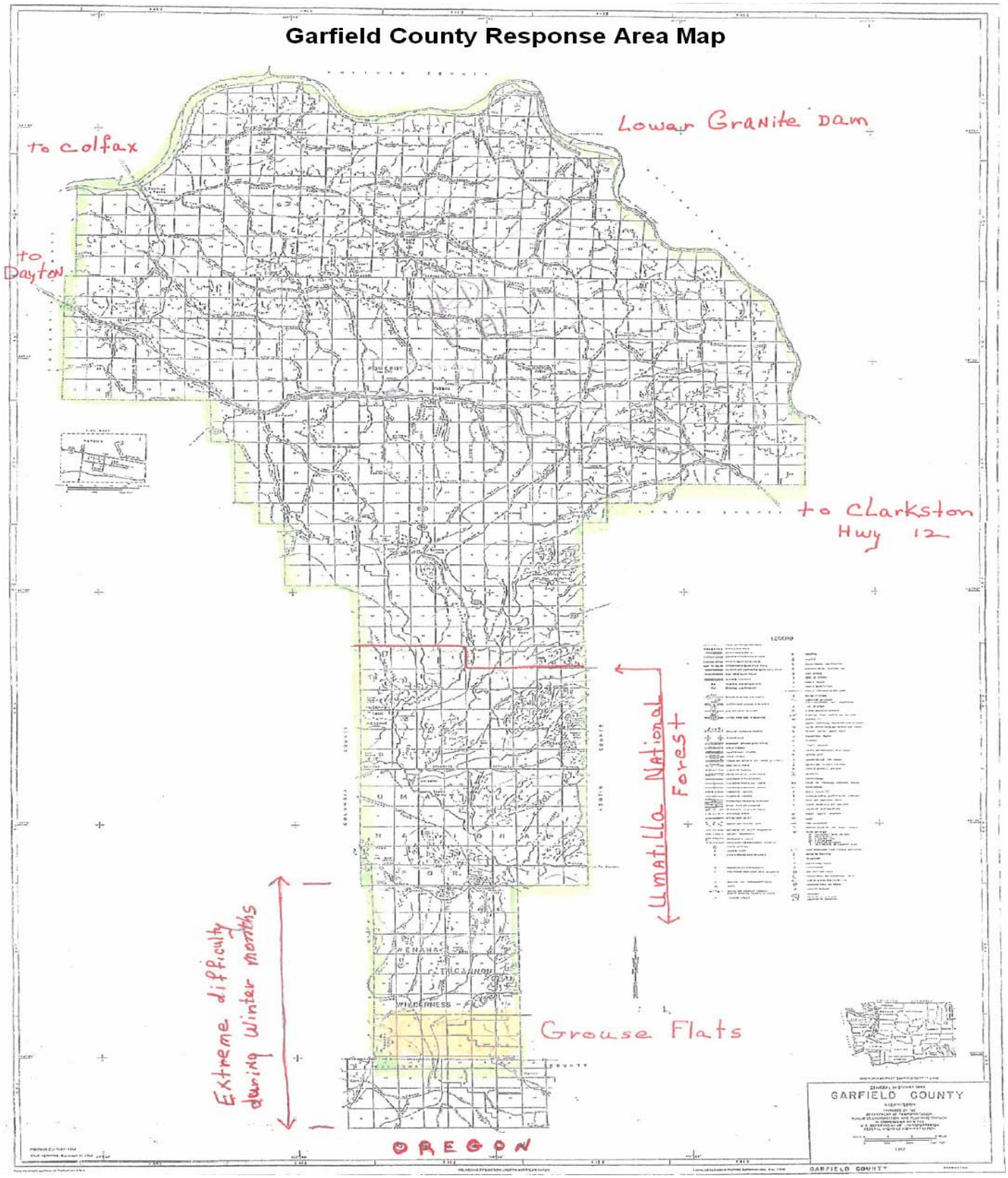
## Ferry County Trauma Response Area Map



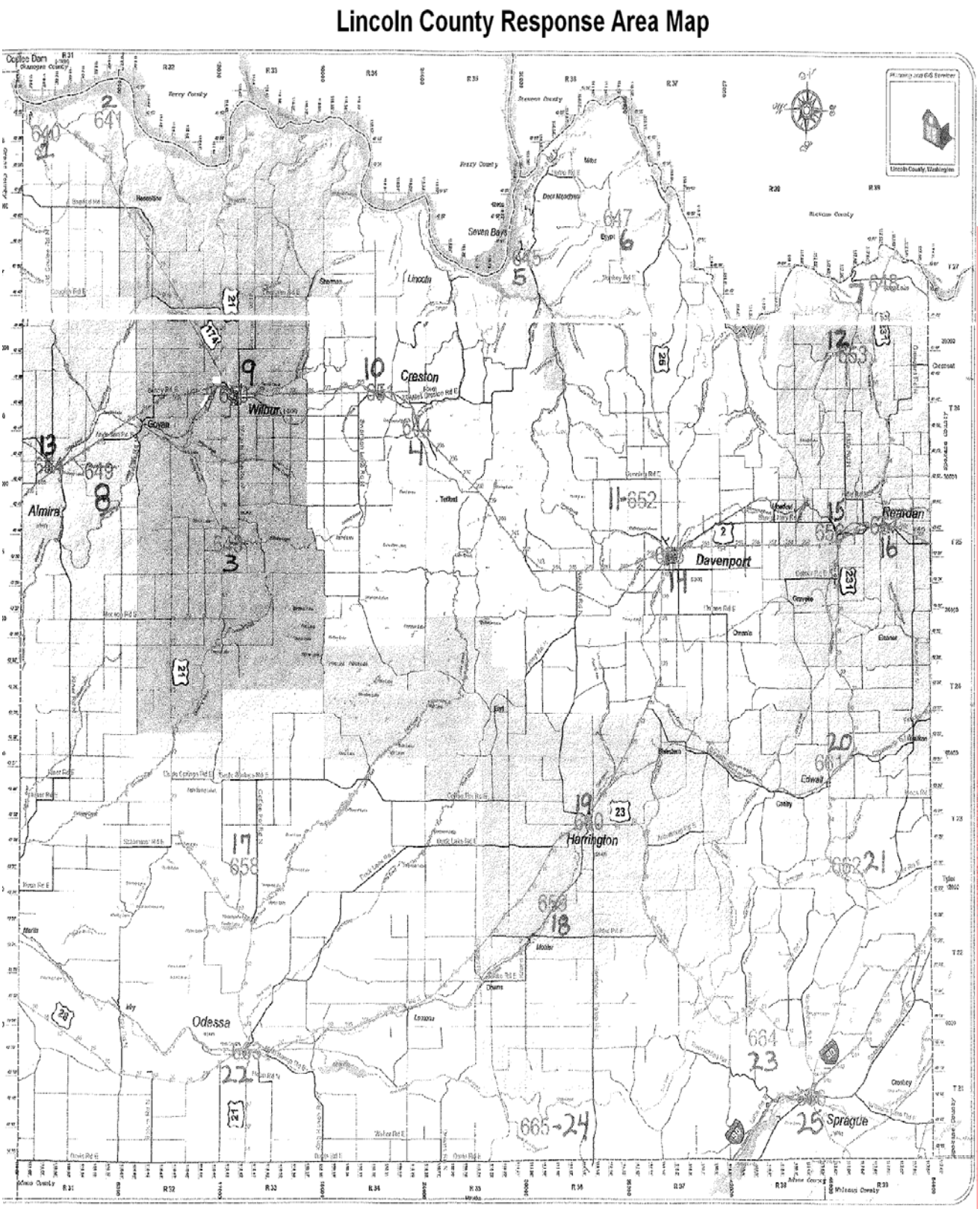
## Garfield County Trauma Response Area Map - A



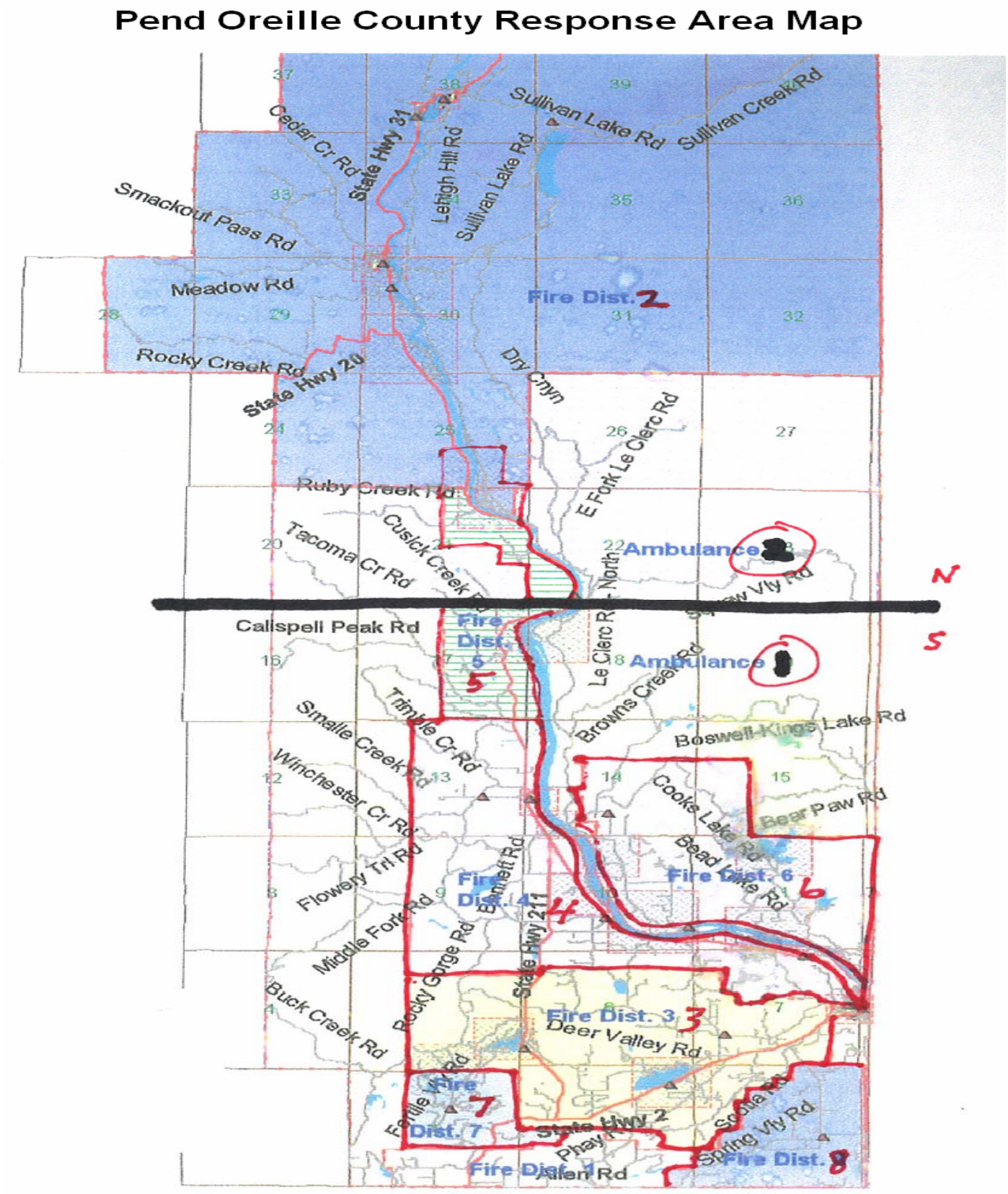
## Garfield County Trauma Response Area Map - B



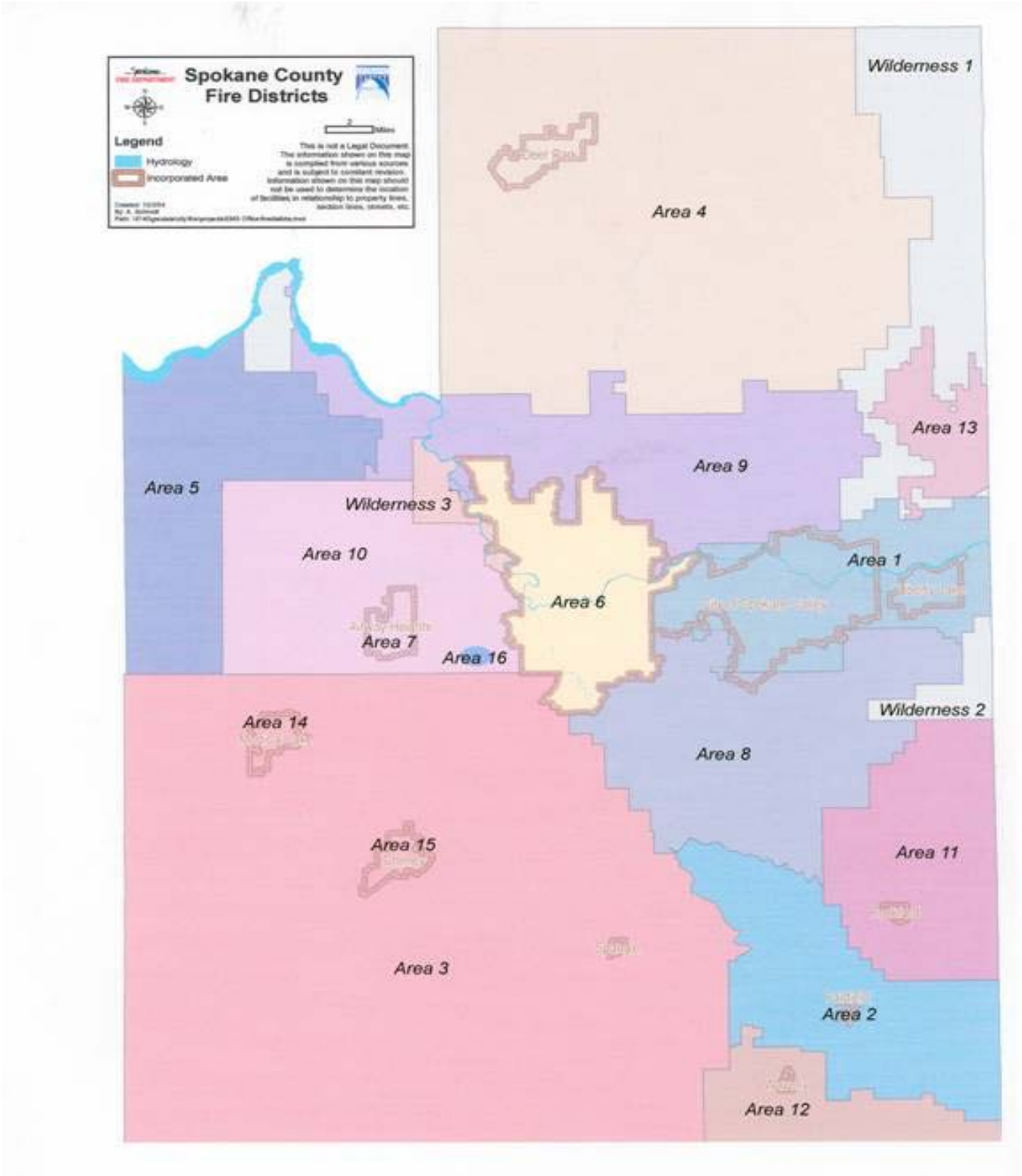
# Lincoln County Trauma Response Area Map



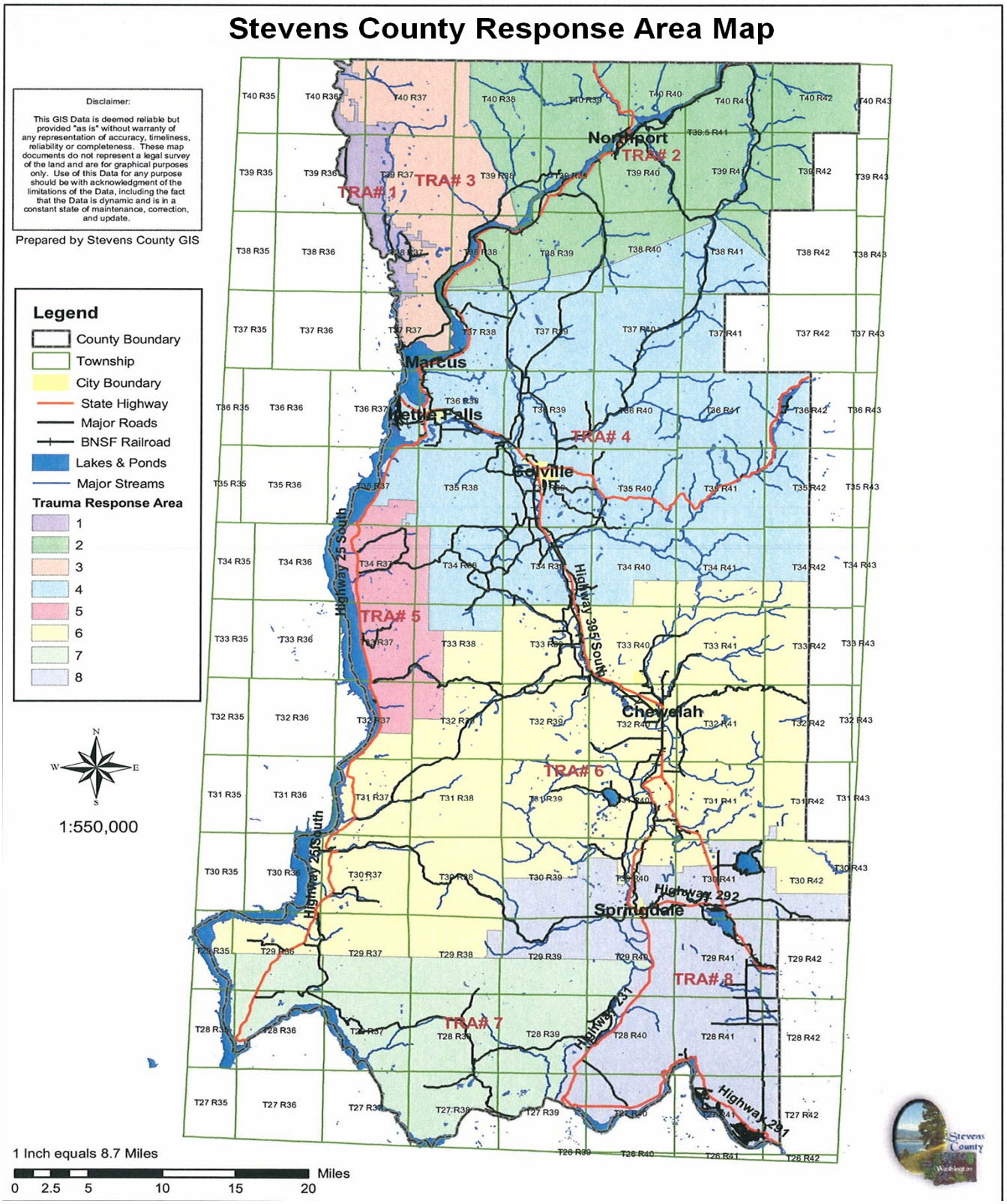
**Pend Oreille County Trauma Response Area Map**



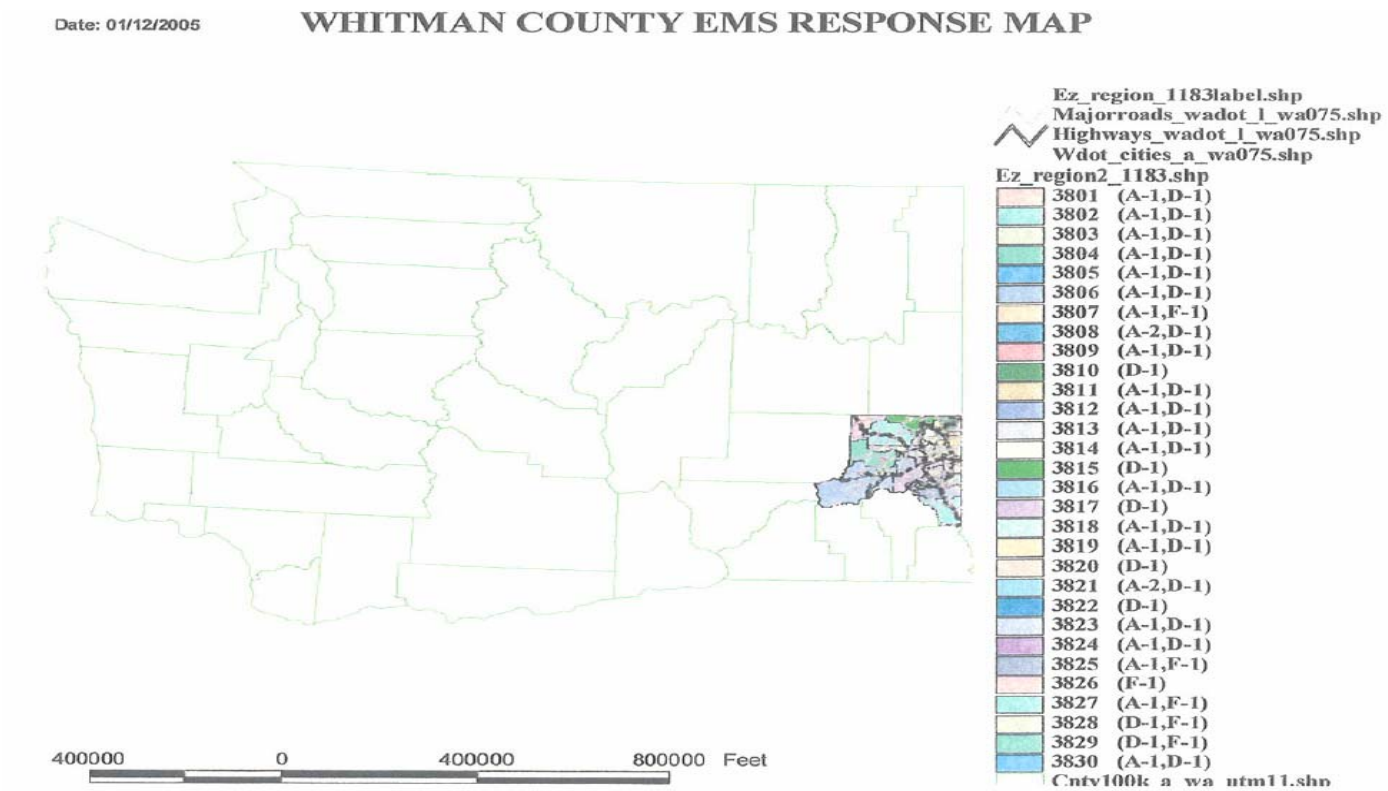
## Spokane County Trauma Response Area Map

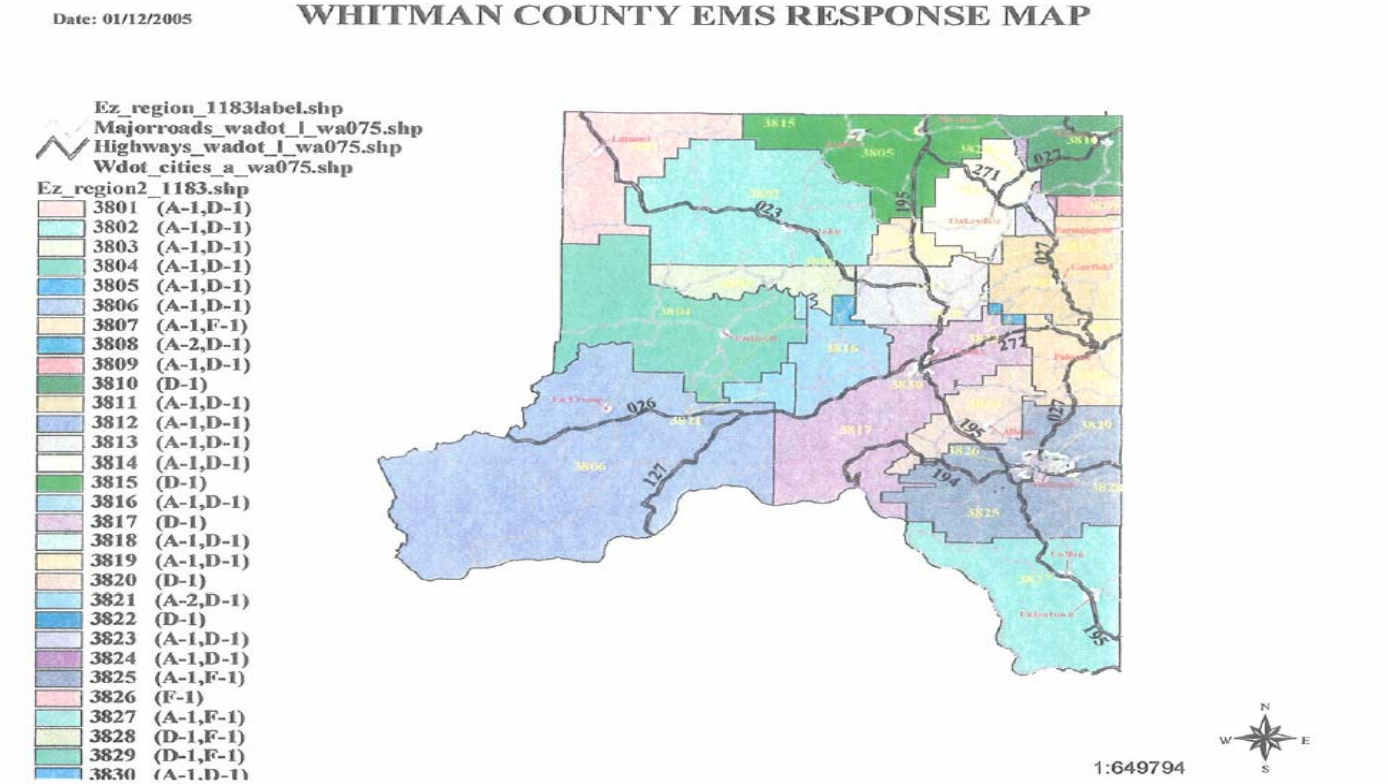


## Stevens County Trauma Response Area Map



## Whitman County Trauma Response Area Map



# Exhibit II – East Region Patient Care Procedures

# Patient Care Procedure #1 - Dispatch Of Medical Personnel

## I. STANDARD:

1. *Licensed aid and/or licensed ambulance services shall be dispatched to all emergency medical incidents by the appropriate 911 center.*

2. *Verified aid and/or verified ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents.*

3. *All licensed and verified aid and licensed and verified ambulance services shall operate 24 hours a day seven days a week. (Current WAC)*

4. *All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.*

## II. PURPOSE: (See County Specific Operating Procedures and Response Area Maps)

1. To provide timely care to all emergency medical and trauma patients as identified in the *Current WAC.*

2. To minimize "System Response Time" in order to get certified personnel to the scene as quickly as possible.

3. To minimize "System Response Time" in order to get licensed and or verified aid and ambulance services to the scene as quickly as possible.

4. To establish uniformity and appropriate dispatch of response agencies.

## III. PROCEDURE:

1. **Following the Region's plan to promote the concept of tiered response, an appropriate licensed or verified service shall be dispatched per the above standards.**

2. **Dispatcher shall determine appropriate category of call using established Washington State EMD Guidelines.**

3. **Response shall be pre-planned by EMD response protocol. (See County Specific Operating Procedures and East Region Response Area Maps.)**

## IV. DEFINITIONS

**"System Response Time"** for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

- "Discovery Time": The interval from injury to discovery of the injury;

- "System Access Time": The interval from discovery to call received;

- "911 Time": The interval from call received to dispatch notified, including the time it takes the call answerer to:
  - Process the call, including citizen interview; and
  - Give the information to the dispatcher;

- "Dispatch Time": The interval from the call received by the dispatcher to agency notification;

- "Activation Time": The interval from agency notification to start of response;
- "Enroute Time": The interval from the end of activation time to the beginning of on-scene time;
- "Patient access time**":** The interval from the end of enroute time to the beginning of patient care;
- "On Scene Time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- "Transport Time": The interval from leaving the scene to arrival at the health care facility.

## V. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted by Regional Council | 6/12/96 |
| Approved DOH | 7/16/96 |
| Implemented | 7/31/96 |
| Reviewed ER Prehospital & Transportation Committee | 11/11/98<br>1/13/99 |
| Adopted by Regional Council | 2/10/99 |
| Final Review PH Committee | 5/17/00 |
| Adopted DOH | 5/17/00 |
| Implemented | 6/00 |
| Reviewed ER Prehospital & Transportation Committee | 2/02<br>3/02<br>4/02 |
| Adopted Regional Council | 4/02 |
| Submitted to DOH for Approval | 8/21/02 |
| DOH Approved | 10/28/02 |
| Reviewed by PH | 3/10/04 |
| Reviewed by PH | 4/14/04 |
| Adopted Regional Council | 4/14/04 |
| Approved DOH | 2/2005 |
| Implemented by Regional Council | 3/2005 |

# Patient Care Procedure #2 - Response Times

## I. STANDARD:

*All verified ambulance and verified aid services shall respond to trauma incidents in a timely manner in accordance with current WAC.*

## II. PURPOSE:

1. To provide trauma patients with appropriate and timely care.

2. To establish a baseline for data requirements needed for System Quality Improvement.

## III. PROCEDURES:

**1. The Regional Council shall work with all prehospital providers and Local Councils to identify response areas as urban, suburban, and rural or wilderness.**

**2. Verified ambulance and verified aid services shall collect and submit documentation to ensure the following response times are met 80% of the time; as defined in the current WAC.**

| | **Aid Vehicle** | | **Ambulance** |
|---|---|---|---|
| **Urban** | **8 minutes** | **Urban** | **10 minutes** |
| **Suburban** | **15 minutes** | **Suburban** | **20 minutes** |
| **Rural** | **45 minutes** | **Rural** | **45 minutes** |
| **Wilderness** | **ASAP** | **Wilderness** | **ASAP** |

**3. Verified ambulance and verified aid services shall collect and submit documentation to show wilderness response times are "as soon as possible."**

## IV. DEFINITIONS:

1. **URBAN**: An unincorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 and a population density over 2,000 per square mile.

2. **SUBURBAN**: An incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.

3. **RURAL**: Incorporated or unincorporated areas with total populations less than 10,000, or with a population density of less than 1,000 per square mile.

4. **WILDERNESS**: Any rural area not readily accessible by public or private road.

5. **"System Response Time"** for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

   - "Discovery Time": The interval from injury to discovery of the injury;
   - "System Access Time": The interval from discovery to call received;
   - "911 Time": The interval from call received to dispatch notified, including the time it takes the call answerer to:
     - Process the call, including citizen interview; and
     - Give the information to the dispatcher;
   - **"Dispatch Time": The interval from the call received by the dispatcher to agency notification;**
     - "Activation Time": The interval from agency notification to start of response;

- "Enroute Time": The interval from the end of activation time to the beginning of on-scene time;
- "Patient access time**":** The interval from the end of enroute time to the beginning of patient care;
- "On Scene Time": The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- "Transport Time": The interval from leaving the scene to arrival at the health care facility.

## V. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted by Regional Council | 6/12/96 |
| Approved DOH | 7/16/96 |
| Implemented | 7/31/96 |
| Revised ER Prehospital & Transportation Committee | 10/14/98 |
| Adopted by Regional Council | 12/16/98 |
| Approved by DOH | 3/17/00 |
| Implemented | 6/00 |
| Reviewed by ER Prehospital & Transportation Committee | 1/02<br>3/11/02<br>4/10/02 |
| Adopted by Regional Council | 4/02 |
| Submitted to DOH for Approval | 8/21/02 |
| DOH Approved | 10/28/02 |

# Patient Care Procedure #3 - Trauma Triage And Transport

## I. STANDARD:

1. *All verified ambulance verified aid services and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in the current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.*

2. *All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30 minute transport time to a designated facility.*

3. Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.

## II. PURPOSE:

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedure.

2. To ensure that all emergency medical and/or trauma patients are transported to the most appropriate designated facility in accordance with the current WAC.

3. To allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

## III. PROCEDURES:

1. The first certified EMS/TC provider determines that a patient:

    a. Needs definitive trauma care
    b. Meets the trauma triage criteria
    c. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure).

2. The provider then proceeds with primary resuscitation for the patient.

3. The provider then determines what step in the Prehospital Triage Procedure that the patient's condition/injuries meet; determination of destination is made based upon the step identified and the following:

    a. For patient meets Step 1 or Step 2 Criteria:

        1. Take the patient to the highest-level trauma center within 30 minutes transport time via ground or air transport according to DOH approved Regional Patient Care Procedures.
        2. Apply "Trauma ID Band" to the patient.

    b. Patient meets Step 3 Criteria:

        1. Take the patient to the nearest designated facility. (No change)
        2. Consult county procedure, IF:
            (a) The patient requests to bypass the nearest facility*
            (b) EMS personnel judgment suggests that the patient be taken to a higher-level facility*
        3. Apply "Trauma ID Band" to the patient.

4. On-line medical control for all counties shall be accessed per COPs

5. 5. Communication will be initiated with the receiving facility as soon as possible to allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

6. ***The receiving facility will notify the verified ambulance service about diversion according to COPs.***

7. Medical control and/or the receiving facility will be provided with the following information, as outlined in the Prehospital Destination Tool:

    a. Identification of EMS agency
    b. Vital signs. (Include First and/or Worst)
    c. Level of consciousness
    d. Anatomy of injury
    e. Biomechanics of injury
    f. Any co-morbid factors
    g. Timely updates on patient status

8. The first EMS provider to determine that a patient meets the trauma triage criteria will attach a Washington State Trauma Registry Band to the patient's wrist or ankle.

9. All information shall be documented on an appropriate medical incident report (MIR) form accepted by the County MPD, which meets trauma registry data collection requirements as outlined in WAC.

**IV. QUALITY IMPROVEMENT:**

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted Regional Council | 6/12/96 |
| Approved DOH | 7/16/96 |
| Implemented | 7/31/96 |
| Revised ER Prehospital & Transportation Committee | 10/14/98 |
| Adopted by Regional Council | 12/16/98 |
| Final Review PH | 5/17/00 |
| Approved DOH | 3/17/00 |
| Implemented | 6/00 |
| Reviewed ER Prehospital & Transportation Committee | 1/02<br>3/11/02<br>4/10/02 |
| Submitted to DOH for Approval | 8/21/02 |
| DOH Approved | 10/28/02 |

## Patient Care Procedure #3A - Triage & Transport For Medical & Non-Major Trauma Patients

### I. STANDARD

*All licensed ambulance services shall transport patients to the most appropriate facility in accordance with County Operating Procedures (COPs).*

### II. PURPOSE

1. To implement regional policies and procedures for all ***medical and non-major trauma patients who do not meet the criteria for trauma system activation*** as described in the Washington Prehospital Trauma Triage Tool.

2. To ensure that all medical and/or non-major trauma patients are transported to the most appropriate facility.

### III. PROCEDURES

**1. Patients not meeting prehospital trauma triage criteria for activation of the trauma system and all other patients will be transported to facilities based on County Operating Procedures (COPs).**

### IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted Regional Council | 6/12/96 |
| Approved DOH | 7/16/98 |
| Implemented | 7/31/96 |
| Revised by ER Prehospital & Transportation Committee | 10/14/98 |
| Adopted by Regional Council | 12/16/98 |
| Final Review PH | 5/17/00 |
| Approved DOH | 3/17/00 |
| Implemented | 4/01/00 |
| Reviewed & revised ER Prehospital & Transportation Committee | 3/11/02 |
| Adopted by Regional Council<br>Submitted to DOH for Approval | 4/10/02<br>8/21/02 |
| DOH Approved | 10/28/02 |

# Patient Care Procedure #3B - Pediatric Trauma Triage & Transport

## I. STANDARD

1. *All verified ambulance, verified aid services, and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.*
2. *All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30-minute transport time to a designated facility.*
3. *Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.*

## II. PURPOSE

1. To ensure that consideration is given to early transport of a child to the regional pediatric trauma center(s) when required surgical or medical subspecialty care of resources are unavailable.

## III. PROCEDURES

1. The first certified EMS/TC provider determines that a pediatric patient:

   A. Needs definitive trauma care
   B. Meets the trauma triage criteria
   C. Presents the factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)

2. The provider then proceeds with airway management and primary resuscitation for the pediatric patient.

3. Apply "Trauma ID Band" to the patient.

4. Take the pediatric patient to the highest-level pediatric trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures and approved County Operating Procedures (COPs).

5. If a pediatric designated facility is not available within 30 minutes, take the patient to the highest adult designated facility within 30 minutes.

## IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

See Next Page

| | |
|---|---|
| Adopted Regional Council | 6/12/96 |
| Approved DOH | 7/16/96 |
| Implemented | 7/31/96 |
| Revised by ER Prehospital & Transportation Committee | 10/14/98 |
| Adopted by Regional Council | 12/16/98 |
| Final Review PH | 5/17/00 |
| Approved DOH | 3/17/00 |
| Reviewed, revised and accepted by ER Prehospital & Transportation Committee | 4/10/02<br>5/8/02 |
| Adopted by Regional Council | 6/12/02 |
| Submitted to DOH for Approval | 8/21/02 |
| DOH Approved | 10/28/02 |

# Patient Care Procedure #4 - Interfacility Transfer Of Adult Trauma Patients

## I. STANDARD

1. All interfacility transfers via ground or air shall be provided by the appropriate licensed and/or verified services with personnel and equipment to meet patient needs.

2. Immediately upon determination that the patient's needs exceed the scope of practice and/or their MPD approved protocols, or physician director standing orders for air ambulance's non-EMS personnel, the licensed and/or verified service personnel shall advise the facility personnel that they do not have the resources to do the transfer.

## II. PURPOSE

Provide a procedure that will facilitate the goal of transferring high-risk trauma and medical patients without adverse impact to clinical outcomes or resource availability.

## III. PROCEDURES

1. Medical responsibility during transport should be arranged at the time of initial contact between receiving and referring physicians. The transferring physician should write the transfer orders after consultation with the receiving physician. Facilities having transfer agreements for trauma patients are attached as a reference.

2. Prehospital MPD protocols shall be followed prior to and during transport.

3. While en-route, the transporting agency should communicate patient status and their estimated time of arrival (ETA) to the receiving facility per Medical Program Director protocols or standing orders for air ambulance's non-EMS personnel.

## IV. DEFINITIONS

- **Scope of Practice**: Patient care within the scope of approved level of certification and/or specialized training.

- **Facilities** are DOH designated trauma care services.

## V. QUALITY ASSURANCE

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Approved DOH | 7/16/96 |
| Implemented | 7/31/96 |
| Reviewed ER Prehospital & Transportation Committee | 11/11/98<br>1/13/99 |
| Final Review ER Prehospital & Transportation Committee<br>Final Revision | 3/10/99<br>5/12/99<br>9/8/99 |
| Regional Council Adopts | 10/99 |
| Final Review PH | 3/17/00 |
| Approved DOH | 5/2000 |
| Implementation | 6/00 |
| Reviewed, revised and accepted ER Prehospital & Transportation Committee | 4/10/02<br>5/8/02 |
| Adopted by Regional Council | 6/12/02 |
| Submitted to DOH for Approval | 6/02 |
| Revised by Prehospital, Adopted RC | 6/03 |
| DOH Approved | 2/2005 |

## Patient Care Procedure #5 - Medical Group Supervisor At The Scene

**I. STANDARD:**

1. *The Incident Command System shall be used.*

**II. PURPOSE:**

1. To define who has overall patient care responsibility at the EMS scene, and to define the line of authority when multiple agencies respond.

**III. PROCEDURE:**

**1.** An incident commander will designate those ICS positions as necessary. When no other incident commander has been appointed the highest medical person shall be in command until a person of equal or greater training relieves him/her. EMS personnel shall direct patient care per County Operating Procedures (COPs) and Medical Program Director protocols.

**2.** The Medical Group Supervisor should be the individual with the highest level of medical certification who is empowered by County Operating Procedures (COPs).

**3.** Diversion from this PCP shall be reviewed by responding agencies, and then reported to the county MPD in the jurisdiction of the incident.

**IV. QUALITY IMPROVEMENT:**

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted by Regional Council | 6/12/96 |
| Approved by DOH | 7/96 |
| Implemented | 7/31/96 |
| Reviewed by ER Prehospital & Transportation Committee | 11/98 |
| Adopted by Regional Council | 2/99 |
| Final Review PH | 5/17/00 |
| Approved DOH | 5/17/00 |
| Implemented | 6/00 |
| Reviewed by ER Prehospital & Transportation Committee | 5/8/02 |
| Adopted by RC | 6/12/02 |
| Submitted to DOH for Approval | 8/21/02 |
| DOH Approved | 10/28/02 |
| Reviewed by ER Prehospital & Transportation Committee | 4/14/04 |
| Adopted by RC | 4/14/04 |
| Submitted to DOH | 9/04 |
| DOH Approved | 2/2005 |
| Implemented | 3/2005 |

## Patient Care Procedure #6 - EMS/Medical Control – Communications

**I. STANDARD:**

1. *Communications between prehospital personnel and receiving facilities will utilize the most effective communications to expedite patient information exchange.*

**II. PURPOSE:**

1. To define methods of expedient communications between prehospital personnel and receiving facilities.

**III. PROCEDURE:**

1. The preferred communications method should be direct between an EMS prehospital provider and the facility. An alternative method of communications should be addressed in County Operating Procedures.

2. Local Medical Program Director, county councils and communications centers will be responsible for establishing communications procedures between the prehospital provider(s) and the facility (ies).

3. The provider agencies will maintain communications equipment and training needed to communicate in accordance with WAC.

4. Problems with communications affecting patient care will be reviewed by the provider agency, county council, MPD, communications center, and if necessary report to the Regional Communications Committee for review**.**

**IV. QUALITY IMPROVEMENT:**

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted Regional Council | 6/12/96 |
| Approved DOH | 7/16/96 |
| Implemented | 7/31/96 |
| Reviewed ER Prehospital & Transportation Committee | 1/13/99<br>2/10/99<br>3/10/99 |
| Final Review PH | 9/8/99 |
| Adopted Regional Council | 10/13/99 |
| Approved DOH | 5/17/00 |
| Implemented | 6/00 |
| Reviewed ER Prehospital & Transportation Committee | 5/8/02 |
| Adopted by Regional Council | 8/21/02 |
| Approved by DOH | 10/28/02 |
| Reviewed by PH | 3/10/04 |
| Adopted Regional Council | 4/14/04 |
| Approved DOH | 2/2005 |
| Implemented | 3/2005 |

## Patient Care Procedure #7 - Helicopter Response

**I. STANDARD:**

1. *Initiate a helicopter response as soon as medically necessary.*

2. *Helicopter transport should be requested when transport time to the appropriate facility may be reduced by more than 15 minutes.*

3. *The highest level of pre-hospital EMS provider on scene may cancel the helicopter response if they determine the patient condition does not warrant air transport.*

Note: County Operating Procedures (COPS) may be added as an addendum to DOH approved PCPS to clarify implementation and operation within each county.

**II. PURPOSE:**

1. To define who may initiate the request for an on-scene medical helicopter and under what circumstances non-medical personnel may request on-scene helicopter service.

**III. PROCEDURE:**

1. The highest level of pre-hospital personnel on scene may request a helicopter be placed on standby or that a helicopter(s) be launched to the scene per COPS.

Note: If the request is to place a helicopter on standby, this helicopter and crew will remain dedicated to the standby until released by the requesting agency.

2. This call shall be initiated through the appropriate medical emergency-dispatching agency per COPS. If possible, landing zone (LZ) or rendezvous sites, and/or LZ hazard assessments, should be identified at this time.

3. The helicopter service communications staff will give an approximate launch time and flight time to the dispatchers requesting service.

4. Helicopter personnel will contact ground EMS personnel as soon as possible while en-route to the scene.

5. Any citizen on scene may request a helicopter be launched to the scene. If a citizen requests a launch, the dispatching service receiving the helicopter request will assure that local EMS is dispatched to the scene at the same time.

6. After assessing the patient, if the highest level EMS personnel on scene determines that the patient's condition does not warrant air transport, they may cancel the responding helicopter and assume responsibility for patient care and transport.

7. Helicopter personnel shall follow the Incident Command System (ICS).

8. Helicopter personnel will make radio contact with the receiving hospital as soon as possible after liftoff from the scene.

**IV. DEFINITIONS:**

1. **Standby: U**pon receiving the request, helicopter dispatch personnel will notify the pilot and crew of the possible flight. The crew will respond to the helicopter and load appropriate equipment. The crew will then remain at or near the helicopter until such time they are launched or released from the standby.

2. **Launch Time:** The time at which the helicopter lifts from the pad en-route to the scene. Assuming the helicopter has been on standby this will require approximately one to two minutes run-up time. Temperatures below freezing may require a little longer run-up.

3. **Flight time:** The estimated time from launch to the helicopter landing at the scene.

4. **Landing Zone (LZ) Hazard Assessment:** On-scene EMS will identify a helicopter-landing zone as close to the scene as safely possible. Ideally this will be a flat area, a minimum of 75 feet by 75 feet during daylight and 100 feet by 100 feet at night. Personnel designating the LZ must complete a hazard assessment including, but not limited to, overhead wires, rocks, uneven surfaces, loose debris, trees, vehicles, foot traffic, and high winds. Such hazards will be relayed to the pilot as the helicopter approaches the LZ.

5. **Rendezvous:** An alternate site for patient transfer from ground ambulance to air ambulance when terrain, weather, or other restraints hinder the helicopter from landing at the requested scene or hospital. The landing zone hazard assessment shall be completed for the rendezvous LZ as for any other LZ.

**V. QUALITY IMPROVEMENT:**

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

| | |
|---|---|
| Adopted by Regional Council | 6/96 |
| Approved by DOH | 7/96 |
| Reviewed by PH & Transportation Committee | 5/9/01 |
| Adopted by Regional Council | 6/13/01 |
| **Approved by DOH** | 4/1/02 |
| Implemented | 5/1/02 |
| Reviewed by PH | 3/10/04 |
| Adopted by Regional Council | 4/14/04 |
| Approved by DOH | 2/2005 |
| Implemented | 3/2005 |

## Patient Care Procedure #8 – All Hazards - Mass Casualty Incident (MCI)

**I. STANDARD**: EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident as identified in this document.

1. All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.

2. Licensed ambulance and licensed aid services shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.

3. EMS certified first response personnel shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and /or in support of verified EMS services.

4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.

5. All EMS agencies working during an MCI event shall operate within the National Incident Management System or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

**II. PURPOSE:**

1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.

2. To implement county MCI plans during an MCI.

3. **Severe Burns**: ***To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region***.

4. To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.

**III. PROCEDURES:**

1. Incident Commander (IC) shall follow the county MCI Plan to inform medical control and the disaster medical control hospital when an MCI condition exists. (Refer to county specific Department of Emergency Management Disaster Plan.)

2. Medical Program Directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be provided by personnel trained to use specific meds, equipment, procedures, and/or protocols until delivery at the receiving facility has been completed.

3. EMS personnel may use the ***Prehospital Mass Casualty Incident (MCI) general Algorithm*** during the MCI incident (attached).

## IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a county provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Post incident after action review is completed within 30 days. It shall be the responsibility of the agency managing the incident to coordinate the review.

## V. Definitions

- **CBRNE -** Chemical, Biological, Radiological, Nuclear Explosive
- **County Disaster Plan –** County Emergency Management Plan (CEMP)
- **Medical Control:** MPD authority to direct the medical care provided by certified EMS personnel in the prehospital EMS system.

**Routing Box**

| | |
|---|---|
| Sample Rec'd from Mike Smith, DOH | 5/2/05 |
| Emailed to Josie Breshears | 5/2/05 |
| Reviewed PH Committee | 5/11/05 |
| Reviewed to RAC | 5/17/05 |
| Reviewed by PH | 6/8/05 |
| Reviewed by PH | 7/13/05 |
| Reviewed by PH | 8/2/05 |
| Distributed to Regional Council for Review | 8/10/05 |
| Distributed to MPDs for Review | 9/23/05 |
| Reviewed by PH | 11.9.05 |
| Reviewed by Chairs & Exec | 11.9.05 |
| Submitted to DOH for approval | 11.9.05 |
| Approved EMS & Trauma Steering Committee | 11.16.05 |

# Prehospital Mass Casualty Incident (IC) General Algorithm

Receive dispatch

Respond as directed

Arrive at scene & Establish Incident Command (IC)

Scene Assessment and size-up

Determine if mass casualty conditions exist

Implement county MCI plan

Request additional resources as needed

The dispatch center shall coordinate notification and dispatch or required agencies and resources including notification of the Regional Disaster Control Hospital (RCH). The Spokane Regional Health District (SRHD) shall be notified in events where a public health threat exists.

Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device)

Initiate START

Reaffirm additional resources

Initiate ICS 201 or similar tactical worksheet (See attached)

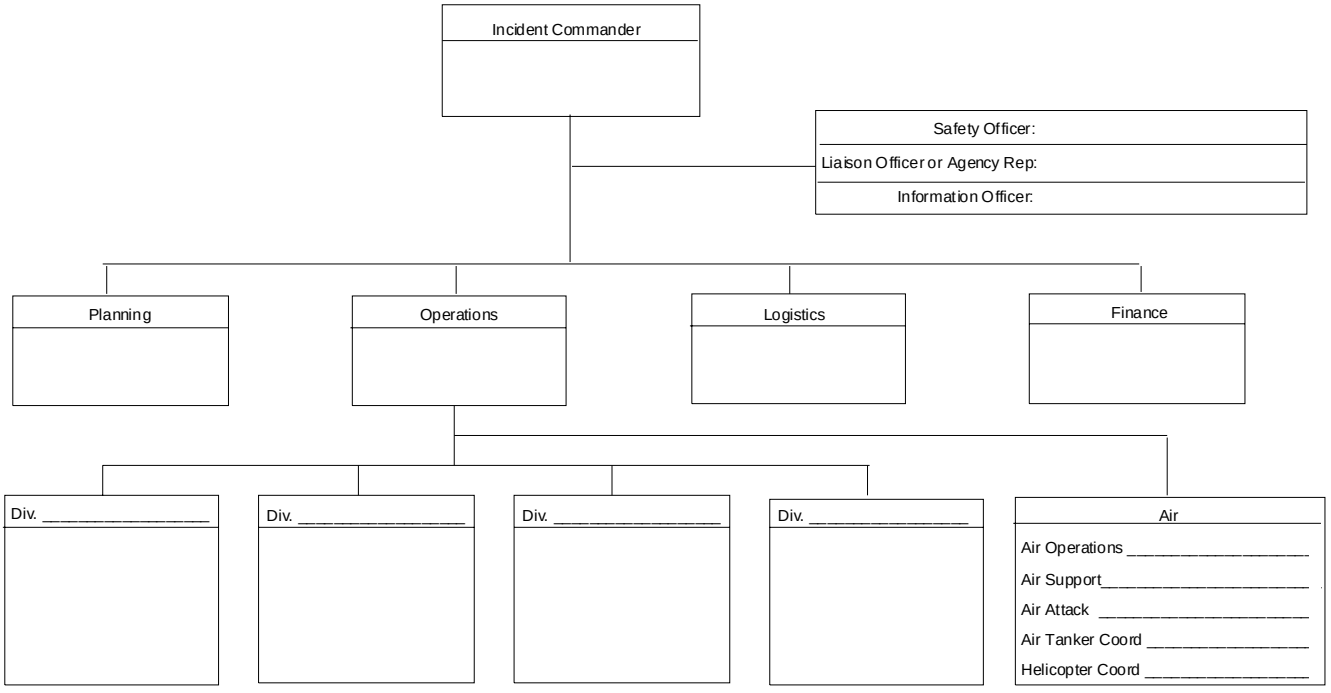
Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary.

Prepare transport vehicle to return to service

| INCIDENT BRIEFING | 1. Incident Name | 2. Date | 3. Time |
|---|---|---|---|

## 4. Map Sketch

## 5. Current Organization




| Page 4 of | 6. Prepared by (Name and Position) |
|---|---|

| 6. Resources Summary | | | |
|---|---|---|---|
| Resources Ordered | Resource Identification | ETA On Scene | Location/Assignment |
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| 7. Summary of Current Actions |
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